POST-MORTEM ORGANS AND TISSUE THROUGH A PROPERTY LAW LENS: HOW PRINCIPLES OF PROPERTY LAW CAN GUIDE LAWMAKERS TO A BETTER ORGAN DONATION FRAMEWORK

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By

MEREDITH D. MALOOF

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Abstract

Across Canada, transplant waitlists far outweigh the organs and tissue made available by the current post-mortem donation system. Every transplant donor is critical to alleviate the ever-growing demand for organs and tissue and there is significant potential for increased donations. Every donation statute in Canada invokes an exception to the deceased's prior consent being binding. The next of kin's power to veto decisions concerning post-mortem donations violates donor autonomy and neither the common law nor statutes explain how this veto should be interpreted and applied. The result is a system of organ donation that depends significantly on the altruism of surviving family members and ignores the need for increased donations. Issues with the current donation frameworks are illuminated by a wills and intestacy analogy.

Basic principles of property law can and should guide lawmakers to meaningful reform of the donation systems. Post-mortem donative instructions should be viewed as sacrosanct, much like the testator's instructions are viewed in the law of wills. Our choices concerning where our post-mortem body parts go are not safeguarded by the same protections afforded to our choices concerning property. This thesis explores the evolution of the common law of ownership regarding the human body and body parts, as well as the historical development of Canada's donation legislation and the meaning of property in theories of jurisprudence. The enforceability of ownership rights in organs and tissue is consistent with popular definitions of property and substantiated further by ostensibly contrasting theoretical views of jurisprudence. This thesis contrasts presumed consent and mandated choice systems of organ donation and proposes an improved system of presumed consent that carefully qualifies the role of family, safeguards individual autonomy, and balances those components with the public need for increased donations.

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Finally, I wish to acknowledge those individuals that currently sit on organ and tissue transplant waitlists. This thesis and these arguments are for them, though they deserve much more than words on paper. It is my sincere hope that legislatures reform the organ donation laws wisely. If governments fail to do so, I am all but sure that organ donation laws will eventually end up before the courts.

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INTRODUCTION

Few things, if any, are as valuable, rare and sought after as donated organs and tissue. Their demand far outweighs their availability, and while hundreds of Canadians die every year waiting for a transplant,[1] thousands more remain on waitlists[2] and continue their race against time. Saskatchewan's organ donation campaign claims that one deceased donor has the potential to provide 8 organ transplants[3] and can improve the lives of more than 75 people through tissue transplantation.[4] But according to the Saskatchewan Health Authority, transplants are only medically feasible in approximately 5 percent of all deaths.[5] Another expert suggests this rate is actually lower and closer to 2 percent.[6]

While these estimates may sound low, they actually mean that of the estimated 9,694 people that died in Saskatchewan in 2018/2019[7], an estimated 194 (2%) to 485 (5%) of people were clinically qualified to donate. However, of those hundreds of potential transplant sources, there were only 16 actual post-mortem donors in the province in 2018.[8] Such a low donation rate is a grim reality and one that is underscored by the fact that approximately 125 individuals were remaining on Saskatchewan's transplant waitlist by the end of 2018.[9]

The Saskatchewan example, above, is not unique. Across Canada, this concerning ratio is common. Waitlists far outweigh the organs and tissue that are made available by the current post-mortem donation system. Nationally, an estimated 287,275 people died in Canada in 2018/2019,[10] and of that large pool of deceased people, only 762 individuals actually had their organs or tissue donated after death.[11] Let that sink in.

It is clear that every single source for transplant is critical to alleviate the ever-growing demand for organs and tissue. It is also clear that there is significant potential for increased donations if organ donation systems effectively tapped into the deceased donor pool. After all, if it is true that 2 to 5 percent of deaths allow for organ donation, then of the 287,275 people that died in Canada in 2018,

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[1] In 2018, 223 Canadians died while waiting for a single or combination transplant. See Canadian Institute for Health Information, *e-Statistics Report on Transplant, Waiting List and Donor Statistics: 2018 Cumulative Report, January 1 to December 31*, Canada, 2018, online: <https://www.cihi.ca/en/e-statistics-on-organ-transplants-waiting-lists-and-donors> at Table 2C [CIHI, 2018 Cumulative Report].

[2] There were 4,492 Canadians awaiting single (4,351) or combination (141) transplants in 2018. For waiting list statistics re single transplants. See *ibid* at Table 2B.

[3] Canadian Institute for Health Information, *Deceased Organ Donor Potential in Canada* (Ottawa: Canadian Institute for Health Information, 2014), online: <https://secure.cihi.ca/free_products/OrganDonorReport_ENweb.pdf> at 4 [CIHI, *Deceased Organ Donor Potential in Canada*].

[4] Saskatchewan Health Authority, "About Donation", online: <https://www.saskhealthauthority.ca/Services-Locations/organ-tissue-donation/Pages/AboutDonation.aspx> [SHA, "About Donation"].

[5] *Ibid*.

[6] Sarah Appleby, Canadian Blood Services Director of organ and tissue donation and transplantation, quoted in Meghan Collie, "More than 200 Canadians died while waiting for organ transplants in 2018: report" (5 December 2019), online: *Global News* <https://globalnews.ca/news/6253000/canada-organ-donation-supply/>.

[7] Statistics Canada, "Estimates of the components of demographic growth, annual: Table 17-10-0008-01", online: <https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1710000801> [Statistics Canada, "Table 17-10-0008-01"].

[8] CIHI, 2018 Summary Statistics, *supra* note 1 at Table 4.

[9] *Ibid* at Table 2A.

[10] Statistics Canada, "Table 17-10-0008-01", *supra* note 7.

[11] CIHI, 2018 Cumulative Report, *supra* note 1 at Table 4.

there were between an estimated 4,984 (2%-762) and 13,601 (5%-762) untapped deceased donors. Even a fraction of that pool could have significantly shrunk the transplant waitlists or even eliminated them altogether.

In 2014, the Canadian Institute for Health Information (CIHI) released their findings from a study on deceased organ donor potential in Canada.[12] It concluded that there was indeed room to increase post-mortem donation throughout the country. According to CIHI, an effective post-mortem donation system requires improving specific components, "from identifying and referring potential donors, to securing patient consent, to managing donors during the dying process, to ensuring hospital resources are in place for organ recovery and that a suitable match is found for transplantation."[13] This thesis focuses on the first two components identified by CIHI, namely "identifying and referring potential donors" and "securing patient consent".

How do we get to a better donation model that improves these two complex and equally important aspects, and why have attempts at reform been insufficient to date? In this thesis, I suggest one way forward is by looking at the organ donation conundrum through a property law lens. After all, it is not uncommon to look at challenges from different angles, and sometimes a new look at an old problem is the push forward to truly impactful and principled solutions. Accordingly, I suggest that basic principles of property law can and should guide lawmakers to meaningful reform of the donation system.

In Chapter 1 of this thesis, I begin by arguing that Canada's current donation frameworks seem married to principles of altruism and substitute decision-making. It is a fact that every single donation statute in Canada, new and old, invokes an exception to the deceased's prior consent being binding. For example, Saskatchewan's legislation provides that "[n]o person shall act on a consent given pursuant to this section if he or she has reason to believe that the consent was subsequently withdrawn."[14] This provision effectively prohibits organ and tissue procurement if there is any reason to believe the deceased's legally binding consent to donate was subsequently withdrawn. Inclusion of these "consent is binding authority exceptions" has helped enable the common practice by provincial donation agencies of advertising statements like: "…it's crucial you have this conversation with family because their consent will be required";[15] or "[a]fter talking about [donating] with your family, they will be asked to sign a consent form saying they have been informed about, and agree with, the donation process… Tell them what you want to happen when you die… Family members will feel better about their decision if they have talked to you and know

[12] CIHI, *Deceased Organ Donor Potential in Canada*, supra note 3.
[13] *Ibid* at 7.
[14] *The Human Tissue Gift Act, 2015*, SS 2015 c H-15.1, s 7(4). For provisions in other provinces to the same effect see *Human Tissue Gift Act*, RSBC 1996, c 21, s 4(4); *Human Tissue and Organ Donation Act*, SA 2006, c H-14.5, s 8(3)(a); *The Human Tissue Gift Act*, SM 1987-88, c 39, CCSM c H180, s 2(3)(a); *Trillium Gift of Life Network Act*, RSO 1990 c H.20, s 4(3); *Human Tissue Gift Act*, RSNB 2014, c 113, s 4(3)(a); *Human Tissue Gift Act*, RSNS 1989, c 215 (repealed; repeal in force January 18, 2021), s 5(3) [*Nova Scotia Act (1989)*]; *Human Tissue Gift Act*, SNS 2010, c 36 (repealed, repeal in force January 18, 2021)]; *Human Organ and Tissue Donation Act*, SNS 2019, c 6 (in force January 18, 2021), s 15(1) [*Nova Scotia Act (2019)*]; *Human Tissue Donation Act*, RSPEI 1988, c H-12.1, s 10(2)(a); *Human Tissue Act*, RSNL 1990, c H-15, s 6(3); *Human Tissue Gift Act*, RSY 2002, c 117, s 4(3); *Human Tissue Donation Act*, SNWT 2014, c 30, s 12(2)(a); and *Human Tissue Act*, RSNWT (Nu) 1988, c H-6, s 1(2)(a).
[15] SHA, "About Donation", *supra* note 4.

what you want."[16] It seems that, regardless of whether we record our consent legally in accordance with the provincial statutes, next of kin are the ultimate decision-makers when it comes to post-mortem organ and tissue donation. In Chapter 1, I argue that this dependence and an over-reliance on altruism can be traced to the development of the common law concerning ownership of human bodies and body parts, and so too can the historical evolution of Canada's provincial donation statutes.

Chapter 2 will then explore two significant components of the organ donation framework: individual autonomy and the public need for increased donations. Responding to the public need for increased donations will require effective identification of potential donors. At the same time, protecting individual autonomy must also be central to any donation framework and therefore safeguarding patient consent is also vital. To further illuminate how autonomy and public policy are offended by the current donation frameworks, Chapter 2 will pose a wills and intestacy analogy to illustrate how our society imposes strict legal rules over the disposal of testamentary property by will or by intestacy procedures, but then refrains from extending similar approaches and principles to the disposition of post-mortem organs and tissue.

Chapter 3 will investigate the age-old question: "what is property?" Through a review of property principles and theory, we will consider why organs and tissue have generally not been subject to personal property rights and whether there should be personal property ownership in our organs and tissue. If we suppose that organs and tissue are property for the purposes of post-mortem donation, then it should follow that donor and non-donor instruction should be protected and legal mechanisms should be in place to mitigate against the waste of viable organs and tissue, thereby appealing to both individual autonomy and the public interest of increasing donation rates.

Chapter 4 will compare mandated choice and presumed consent systems of organ donation. In doing so, we will look beyond Canada, to the United States and Europe, to see if other countries have been successful at striking a balance between protecting individual autonomy while at the same time increasing donations. In reviewing these foreign systems and results from domestic and international surveys on presumed consent, I argue that the default mechanism of the presumed consent system, while largely misunderstood by society, is a key component that can set presumed consent above all other frameworks and offers the best avenue to a balanced system.

In Chapter 5, the final chapter of this thesis, I will argue that a reformed presumed consent system can work to balance donor and non-donor autonomy against the public's need for increased donations. In establishing this argument, I will outline specific components that would be necessary for a reformed presumed consent system to strike the correct balance.

Ultimately, this thesis aims to show how a property law lens inspires meaningful and large-scale reform to the ongoing donation problem. Not everyone will agree with taking a property lens to this issue; however, I believe this thesis can add value to the already considerable literature and debate on the topic. People have a common understanding of – and appreciation for – property. In some form or another, property is vital to everything we do, and this important relationship we

[16] My Health Alberta, "Consent to Donate", online: <https://myhealth.alberta.ca/alberta/Pages/organ-and-tissue-donation-consent-to-donate.aspx>.

have with property is recognized and given effect by property law. In my view, there are critically important relationships between people and post-mortem organs and tissue that have fallen into a gap in the law which has helped enable the donation problem. Property law not only helps to explain these relationships but can also expand to recognize this area in a way that effects meaningful reform to the post-mortem donation system.

CHAPTER 1
Overview of Canada's Donation Model

Provincial and territorial statutes outline the procedural framework for post-mortem organ and tissue donation. Today, all provinces and territories in Canada have implemented legislation concerning human organ and tissue donation.[1] What is evident upon review of the procedural frameworks governing post-mortem donation across Canada are the common features of "altruism" and "substitute consent".[2] These are two key components of post-mortem donation and are not the only similar features among the jurisdictional models. Across Canada, post-mortem organ donation models are largely uniform and provide near identical powers for donors and substitute decision-makers. The reason for this is twofold and can be traced to the development of the common law concerning ownership of human bodies and body parts as well as to the evolution of donation statutes in Canada. What follows is a summary of both of those areas.

1.1 The Common Law of Ownership Regarding the Human Body and Body Parts

a) Ownership in a Living Human Body:

At common law, the concept of property tends to centre around the elements of possession, use and ownership.[3] In the most basic sense, we indeed possess and use our bodies in our day-to-day life. Yet, in the legal sense, the common law has long-held that a living human body is incapable of being owned.[4] Correlating to this rule was the common law's age-old perception that people do not even possess their own body or body parts.[5] The effects of these principles have been many. For example, if we cannot own our bodies, then we cannot own another person's body and thus people cannot be sold or bought.[6]

Although the common law abstains from explicitly recognizing property in the living human body, laws have been established to protect bodily integrity and autonomy.[7] For example, the law at one

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[1] See *Human Tissue Gift Act*, RSBC 1996, c 211 [*BC Act*]; *Human Tissue and Organ Donation Act*, SA 2006, c H-14.5 [*Alberta Act*]; *The Human Tissue Gift Act, 2015*, SS 2015 c H-15.1 [*2015 Saskatchewan Act*]; *Human Tissue Gift Act*, SM 1987-88, c 39, CCSM c H180 [*Manitoba Act*]; *Trillium Gift of Life Network Act*, RSO 1990 c H.20 [*Ontario Act*]; *Human Tissue Gift Act*, RSNB 2014, c 113; *Human Tissue Gift Act*, RSNS 1989, c 215 [repealed; repeal in force January 18, 2021]; *Human Tissue Gift Act*, SNS 2010, c 36 [repealed, repeal in force January 18, 2021]; *Human Organ and Tissue Donation Act*, SNS 2019, c 6 [in force January 18, 2021] [*Nova Scotia Act (2019)*]; *Human Tissue Donation Act*, RSPEI 1988, c H-12.1; *Human Tissue Act*, RSNL 1990, c H-15; *Human Tissue Gift Act*, RSY 2002, c 117; *Human Tissue Donation Act*, SNWT 2014, c 30; *Human Tissue Act*, RSNWT (Nu) 1988, c H-6 [*Nunavut Act*].

[2] See Joan M. Gilmour, ""Our" Bodies: Property Rights in Human Tissue" (1993) 8:2 Can J L & Soc 113 at 116. See also Barbara von Tigerstrom, "Human Tissue Legislation and a New Medical Paradigm: Governing Tissue Engineering in Canada" (2015) 8:2 McGill JL & Health S1 at S11.

[3] *Lam v University of British Columbia*, 2013 BCSC 2094 at para 31, 20 BLR (5th) 139 [*Lam* (2013 BCSC)]; aff'd 2015 BCCA 2, [2015] 4 WWR 213 [*Lam* (2015 BCCA)].

[4] *Yearworth v North Bristol NHS Trust*, [2009] EWCA Civ 37 at para 30, [2010] QB 1 [*Yearworth*].

[5] *Ibid* at para 30, citing *R v Bentham*, [2005] UKHL 18, [2005] 1 WLR 1057.

[6] Notwithstanding these principles, the slave trade certainly recognized a proprietary interest in the human body between the 17th and 19th centuries in Canada. It wasn't until the 19th century that the law prohibited ownership of other people and thus the sale of others and ourselves was also barred. The Court in *Yearworth* noted that it took until the nineteenth century for the law to recognize that our bodies cannot be the property of other persons if they cannot be our own property. See *Yearworth*, *ibid.*

[7] *Yearworth*, *supra* note 4.

point prohibited the destruction of our own bodies, since we ought not destroy what we do not own.[8] Hence, attempting suicide was considered a criminal act and was punishable under Canada's first *Criminal Code*, enacted in 1892.[9] In 1972, 80-years after enacting that prohibition, Parliament decriminalized attempted suicide.[10] Interestingly too, is that in 2015 physician assisted suicide was also decriminalized.[11]

The law's evolution concerning suicide does not necessarily depart from the age-old notion that 'suicide is a sin', but its evolution could be attributed to a modern interpretation that 'any person in their right mind would not kill themselves' and since 'we ought not destroy what we do not own', the court's intervention is necessary to establish *who* meets the legal threshold for assisted suicide. This modern interpretation could be consistent with the notion that we 'do not own our bodies', or in contrast it could be a signal that the law is evolving to establish more protections for bodily integrity and autonomy.

b) Ownership in Parts of a Human Body:

i. Conversion of Excised Organs and Tissue

As previously noted, the common law has long held that a living human body is incapable of being owned.[12] This foundational principle has affected the common law approach to ownership in human body parts. For over two decades, the 1990 case of *Moore v Regents of the University of California* was widely recognized as a leading authority on the law of ownership of parts excised from a living human body.[13] Although an American precedent, it has served as a persuasive decision in Canada.[14] The case concerned a patient who had consented to the removal of his spleen and other parts of his body (i.e. blood, blood serum, skin, bone marrow aspirate, and sperm) on the representation that such tests were essential for his health and well-being.[15] However, unbeknownst to the patient, the doctors and others were using his cells to generate a cell-line with high economic

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[8] The concept that "we ought not destroy what we do not own" has age-old religious roots. Per 1 Corinthians 6:19-20, "Know ye not, that your body is the temple of the Holy Ghost, which is in you, whom ye have of God? and ye are not your own, For ye are bought for a price: therefore glorify God in your body, and in your spirit: for they are God's": *The holy Bible: that is, the sacred Scriptures contained in the Old and New Testament* (London: M. Lewis, Paternoster-Row, 1775) at 1019. The concept has also been analyzed in early theory. *Per* John Locke, "…no body can transfer to another more power than he has in himself; and no body has an absolute arbitrary power over himself, or over any other, to destroy his own life, or take away the life or property of another." See Chapter XI "of the extent of the legislative power" in *Second Treatise of Government* (Indianapolis and Cambridge: Hackett Publishing Company, 1980) online <http://www.gutenberg.org/files/7370/7370-h/7370-h.htm>.

[9] *Criminal Code, 1892*, SC 1892, c 29, ss 237, 238 (repealed). See also Florence Kellner, "Suicide in Canada" (2006 July 2; last edited 2016 October 3) *The Canadian Encyclopedia*, online: <http://www.thecanadianencyclopedia.ca/en/article/suicide/> [Kellner].

[10] Kellner, *supra* note 9.

[11] *Carter v Canada (Attorney General)*, 2015 SCC 5, [2015] 1 SCR 331. What the decriminalization of assisted suicide arguably signifies, at least in the 'patient autonomy' aspect of the organ donation context, will be discussed in Chapter 2 of this thesis.

[12] *Yearworth*, *supra* note 4 at para 30.

[13] *Moore v Regents of the University of California*, 51 Cal (3d) 120 (1990), 793 P2d 479 [*Moore*].

[14] The Court in *Piljak Estate v Abraham*, 2014 ONSC 2893, [2014] OJ No 2665 (QL) [*Piljak*] relies on the conclusions of Dr. Carol C. Cheung *et al.* in "Defining diagnostic tissue in the era of personalized medicine" (2013) 185:2 CMAJ, 135-139, concerning who "owns" excised human tissue. In that article, the authors cite to *Moore*, *supra* note 13, for the principle that a patient does not have a proprietary interest in excised cells. At para 26 of *Piljak*, Master Dash states "[t]he authors note that their conclusion has been supported by American jurisprudence. While this is not binding on me I find the reasoning [compelling] and I adopt its conclusions."

[15] *Moore*, *supra* note 13.

potential.[16] The patient's action for breach of fiduciary duty succeeded while his action in conversion did not.

The patient in *Moore* submitted that the defendants improperly interfered with his right of possession, use or control of his property, and that he continued to own his cells after their removal from his body and never consented to their use in medical research.[17] The majority held that conversion did not apply because the subject matter of the patented cell-line and all products derived from it were not the patient's property. There was no expectation that the patient would retain possession of his cells once they had been removed from his body, and to establish conversion the patient would have had to retain a sufficient ownership interest in them.[18] The Court held that theories of fiduciary duty and informed consent are sufficient to cover the interests of the patient in a case such as this. A breach of fiduciary duty or lack of informed consent can form the basis for an action, and therefore doctors must "disclose personal interests unrelated to the patient's health, whether research or economic, that may affect [the patient's] medical judgment."[19] However, the Court determined that it would be unreasonable to hold researchers liable for conversion when they may unknowingly be in possession of body parts that were not authorized for use in research by the patient.[20] It would be an issue of public policy if that sort of liability existed as it could seriously hinder important research and advancements in healthcare. The Court noted further that the law of conversion has well-established that a converter "is entitled to the benefit of any work or labor that he has expended on the [property]…."[21] Thus, "if the great bulk of the value of a cell line patent and derivative products is attributable to the efforts of medical researchers and drug companies,…rather than to the "raw materials" taken from a patient…the patient's damages will be correspondingly limited."[22] In this way, the common law of conversion requires body parts to have acquired additional attributes by work or skill in order to be considered property. But as we will see, conversion is not the only instance when 'property' can be declared in an excised body part.

ii. Bailment of Sperm

In the 2009 decision of *Yearworth v North Bristol NHS Trust* [*Yearworth*][23], the English and Wales Court of Appeal broke new ground in ruling that sperm was property. The claimants were patients and, having been diagnosed with cancer, they rendered samples of their sperm to be held at the defendant hospital before undergoing chemotherapy treatment. The samples were stored frozen in liquid nitrogen but subsequently thawed when the nitrogen levels fell too low. The hospital relied on the common law rule that an excised body part is incapable of being owned but the Court rejected this argument, finding that the claimants did have ownership in their sperm and that the claimants gratuitously bailed their sperm to the hospital. Therefore, the hospital was liable to the claimants under the law of bailment. Thus, while the common law required excised body parts to have acquired additional attributes by work or skill in order to be considered property, the common law subsequently recognized that there are particular contexts where excised parts are still capable

[16] *Ibid.*
[17] *Ibid.*
[18] *Ibid* at 129.
[19] *Ibid.*
[20] *Ibid* at 143-148.
[21] *Ibid* at 159, citing Harper *et al.*, *The Law of Torts* (2d ed. 1986) § 2.34 at 234.
[22] *Moore*, *supra* note 13 at 159.
[23] *Yearworth*, *supra* note 4.

of being property without such added attributes. The Court elaborated on this principle, stating at para 45:

> In this jurisdiction developments in medical science now require a reanalysis of the common law's treatment of and approach to the issue of ownership of parts or products of a living human body, whether for present purposes (viz. an action in negligence) or otherwise.[24]

iii. Stored Embryos

In 2005, some 15 years after the *Moore* decision, claims of property in human biological material arose in Canada. At that time, the issue before Alberta's Court of Queen's Bench in *C.C. v A.W.* [*C.C. v A.W.*][25] was whether stored embryos are property. That case involved a gift of sperm by the respondent to the claimant for the purposes of assisting the claimant in conceiving children. Through the use of that sperm, embryos were created and the claimant conceived and delivered twins. The respondent refused to consent to the release of the remaining four embryos to the claimant from the fertility clinic in which they were stored. In assessing the context in which the gift of sperm was given, the Court noted that the respondent's gift was unqualified; given in anticipation that the claimant would conceive children; and that the respondent was well-aware that the claimant could use the fertilized embryos "when and how she chose".[26] The Court concluded that stored embryos were indeed property, and as the chattel and property of the claimant, the respondent had no legal interest to "control or direct their use in any fashion".[27]

iv. Stored Sperm

Since *C.C. v A.W.*, other Canadian jurisdictions have concluded that stored sperm in particular contexts is property.[28] One particular Canadian case considered a situation comparable to the *Yearworth* action. In *Lam v University of British Columbia*,[29] the Supreme Court of British Columbia heard a case concerning the malfunction of a freezer storing hundreds of sperm samples. The freezer malfunction subsequently damaged the sperm. A class-action suit was brought against the defendant University by hundreds of donors and the Court held that the University was liable for the damage, ruling that sperm is property and falls within the definition of "goods" stored in a warehouse.[30] The Court of Appeal for British Columbia dismissed the University's appeal and upheld the lower Court's decision.[31]

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[24] *Ibid* at para 45.
[25] *C.C. v A.W.*, 2005 ABQB 290, 50 Alta LR (4th) 61.
[26] *Ibid* at para 21.
[27] *Ibid*.
[28] See also *K.L.W. v Genesis Fertility Centre*, 2016 BCSC 1621; *J.C.M. v A.N.A.*, 2012 BCSC 584; *Lam* (2015 BCCA), *supra* note 3; *Kate Jane Bazley v Wesley Monash IVF Pty. Ltd.*, [2010] QSC 118 (Queensland SCTD); *Jocelyn Edwards: Re the Estate of the late Mark Edwards*, [2011] NSWSC 478.
[29] *Lam* (2013 BCSC), *supra* note 3.
[30] *Ibid* at para 49.
[31] *Lam* (2015 BCCA), *supra* note 3. The University sought leave to appeal to the Supreme Court of Canada and that application was dismissed on February 17, 2011, without costs.

v. Excised Diagnostic Tissues

More recently, in the 2014 case of *Piljak Estate v Abraham*,[32] the Ontario Superior Court concluded that excised human tissue was personal property. The deceased's estate sought to have an inspection performed on tissue samples taken from prior medical tests, and the relevant statute allowed for the inspection of "personal property where it appears to be necessary for the proper determination of an issue in a proceeding."[33] Hence, the issue arose as to whether the excised human tissue was personal property. In concluding that the excised tissue was property, the Court affirmed that excised diagnostic tissue became part of the "medical record" once removed from a patient's body and thus possession and ownership transferred from the patient to the institution or hospital.[34] By this line of reasoning, the Court also adopted the view that the organs and tissue were the patient's property up until the point that they became excised.[35]

As we saw in the above discussion, the common law has long held that a living human body cannot be owned or possessed, but as we have seen, time and technology have carved out instances where the common law recognizes ownership of human biological material. Likewise, in the post-mortem context, the common law continues to abide by the general rule that there can be no ownership in a human corpse; however, courts have since carved out a number of exceptions to make findings of property in the dead. The following discussion provides an overview of the common law of property in the post-mortem context.

c) The Human Corpse: "No Ownership"

For centuries, the English common law held that a human corpse was incapable of being owned. There were several reasons for this longstanding rule. First, the common law held that ownership of a living human body is not possible.[36] Likewise, the common law also held that a person cannot own his body or any part within it. Thus, it followed as nonsensical to expect ownership in a human corpse when it was impossible to hold ownership in a living human body.[37] Second, the human body was perceived as the Holy Ghost's temple. Anything done to the body beyond burial was considered sacrilegious.[38] Third, conflicting claims of ownership over a corpse could slow down the burial process and increase the chance of disease spreading from the dead to the living. Before the days of modern refrigeration, a prompt burial was in the best interests of public health.[39]

These reasons underscored the Court's decision in the 1882 case of *Williams v Williams*.[40] In that case, the testator died and the executors buried his body. In a codicil to his will, the testator instructed his executors to give his corpse to Ms. Williams, and by way of a letter, he instructed Ms. Williams to arrange for a specific cremation of his body and to place his ashes in a specified

[32] *Piljak, supra* note 14. In this case, the patient died of colorectal cancer. The patient's estate brought an action in negligence against the doctor, alleging a breach in the standard of care by failing to detect the cancer in medical tests that he had previously performed on the patient.
[33] *Ibid* at para 17.
[34] *Ibid* at para 26. For "medical record", see "records of personal health information" as defined in *Hospital Management*, RRO 1990, Reg 965 at s 1.
[35] *Piljak, supra* note 14 at para 26.
[36] *Yearworth, supra* note 4 at para 30.
[37] *Ibid* at para 31.
[38] *Ibid.*
[39] *Ibid* .
[40] (1882) 20 Ch D 659 [*Williams*].

vase, and upon doing so, he instructed her to claim her expenses from the executors. Ms. Williams caused the corpse to be dug up, and following the testator's written instruction, Ms. Williams attempted to claim her expenses against the executors. The Court dismissed her claim, holding that there was no property in the human corpse and that a body could not be disposed of by will. Since there was no property in the corpse, Ms. Williams had no right to have the corpse dug up and cremated, and it would be inequitable to order that Ms. Williams be reimbursed for expenses that she had no right to incur in the first place.

i. The Human Corpse: "No Ownership" Exception #1: Preservation

Property When Preserved for Exhibition

Large developments to the common law of ownership in a human corpse came out of Australian courts, much as they had come out of English courts. In the 1908 Australian case of *Doodeward v Spence*[41] a physician preserved the body of a two-headed stillborn baby in spirits. When the doctor eventually died, the subject matter was sold and came to be possessed by C, who showcased the "dead-born [fetal] monster" for profit.[42] A police officer then seized it with the intent to have it buried and C brought an action for detinue. Finding in favour of C's action, the majority held that a human corpse is capable of becoming property and that a person has a right to retain lawful possession of a body or body part where that person has exercised skill or work over the body or body part so as to give it attributes that differentiate the subject matter from that of a corpse or body part merely awaiting burial.[43] The dissent held firm to the principle that there could be no ownership of a human corpse, while the majority essentially carved out the first exception to that rule.

Not Property When Preserved for Autopsy

In 1996, almost a century after *Doodward v Spence* was decided, the England and Wales Court of Appeal heard *Dobson v North Tyneside Health Authority and Another*.[44] In this case, a pathologist removed the brain from a woman who died of a brain tumour, and submerged it in paraffin wax to preserve it for his further examination, which never happened. The corpse was buried and the brain was brought to a second hospital for storage. The woman's next of kin eventually began an action in negligence against her doctor and sought to have the brain examined for evidentiary purposes, however the preserved brain could not be located. The next of kin therefore brought a suit against a second doctor located at the second hospital on allegations that the second doctor either destroyed or misplaced the brain. Their action against the second doctor was struck on the basis that there was no reasonable cause of action, and their subsequent appeal was dismissed. In coming to its decision, the Court noted that it agreed with the Court's determination in *Doodeward*, but when applying it to the facts of this case, it distinguished the brain preserved in paraffin wax from the *Doodeward* fetus preserved in spirits, noting that the fetus was preserved for future use as an exhibit whereas the brain was preserved only for further autopsy, and for no additional use beyond that. As such, the Court found that preservation does not always cause an object to become property and the process surrounding an autopsy will not render a body or body part into something capable of ownership. In this way, the Court determined that the brain never became something that the next of kin were entitled to possess.[45]

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[41] (1908) 6 CNL 406, [1908] HCA 45 [*Doodeward*].
[42] *Ibid.*
[43] *Ibid.*
[44] [1997] 1 WLR 596, [1996] 4 All ER 474 [*Dobson*].
[45] *Ibid.*

Property When Preserved for Research and Teaching

In 1997, the scope of the Court's ruling in *Dobson* was put to the test in *R v Kelly and Lindsay*.[46] In that case, two defendants were charged, convicted and sentenced for theft of human body parts used for training purposes at the Royal College of Surgeons. In appealing their conviction and sentence, the defendants argued that they did not commit theft because the body parts were not property and were therefore not capable of being the subject of theft.[47] The Court dismissed that argument, reiterating that a corpse alone cannot be the subject of property except if the corpse or parts thereof acquired different attributes from a person's work or skill. On that point, the Court went one step further, expanding the range of attributes that a human corpse is capable of acquiring, finding that the body parts were the property of the Royal College of Surgeons because they were training materials and therefore had "a use or significance beyond their mere existence."[48] The Court made important observations about the common law's view of property in human bodies:

> …the common law does not stand still. It may be that if, on some future occasion, the question arises, the courts will hold that human body parts are capable of being property for the purposes [of a particular piece of legislation], even without the acquisition of different attributes, if they have a use or significance beyond their mere existence. This may be so if, for example, they are intended for use in an organ transplant operation, for the extraction of DNA or, for that matter, as an exhibit in a trial.[49]

Interestingly, the Court signals that organ transplantation may substantiate a finding of property in organs and tissue. In my view, if one intends to transfer their organs and tissue into the donation system for transplant into another person, those body parts quite obviously have "a use or significance beyond their mere existence." From the Court's reasoning in *R v Kelly and Lindsay*, it should therefore follow that those organs and tissue are property, at least for the purposes of determining those transfers pursuant to the donation legislation. However, as we have seen, courts make very narrow findings of property in body parts, and the question of whether there is property in organs and tissue for the purposes of facilitating a transplant pursuant to the donation legislation has yet to be tried in a court of law. This is somewhat confounding considering the donation legislation has been in effect for decades and the problems of low donation rates and autonomous interference are by no means new issues.

De facto Property When Determining Proper Disposal

With respect to bodies awaiting burial, in *Re JS*[50] the England and Wales High Court reviewed the law concerning the disposal of a deceased body as established in *Williams* and observed that "[t]he administrator or executor of the estate has the right to possession of (but not property in) the body and the duty to arrange for its proper disposal."[51] However, as we will see in the Chapter 3 analysis of "what is property", a *right* to possession is how property is generally distinguished from mere possession. Thus, even though the Court in *Re JS* insists otherwise, it effectively granted a limited form of property in the deceased's body.

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[46] [1999] QB 621, [1998] 3 All ER 741 [*R v Kelly and Lindsay*].
[47] *Ibid.*
[48] *Ibid.*
[49] *Ibid.*
[50] *Re JS*, [2016] EWHC 2859 (Fam) [*Re JS*].
[51] *Ibid* at para 47.

The facts of the case concerned a 14-year-old terminally ill applicant seeking a means to decide what happens to her body at the end of her lifetime and after her death. More specifically, she sought to have her remains cryogenically frozen and stored indefinitely in a clinic in the United States. In approving her application, the Court noted that entrusting the child's mother to arrange for the cryogenic freezing of the child's body does not contravene the principle in *Williams* that a body is not property and therefore cannot be disposed of by will.[52]

Thus, the *Re JS* principle is narrow and tells us that a person still cannot control how their own body is disposed of after death.[53] Although a deceased person's wishes are relevant, they are not binding on third parties. With the *Williams* principle in mind, the Court in *Re JS* makes clear that it "is not deciding or approving what should happen, but is selecting the person best placed to make those decisions after JS's death."[54] In other words, the Court places no legal obligation whatsoever on the mother to carry out the deceased's wishes.

The narrow scope of *Re JS* is interesting because the common law has, in my view, added an exception to the general rule established in *Williams*, i.e. that there is no property in a corpse. The Court in *Re JS* gives a *de facto* property right to an executor or administrator, which includes what is to happen to the body after death. In doing so, it highlights the fact that there does not seem to be a principled reason for denying that same power to a person prior to their decease. Although "proper disposal" has yet to be defined, the Court signaled that customs change over time,[55] which I take as meaning that the law can continue to recognize new ways to properly dispose of bodies and therefore new limited forms of property will develop as a result.[56]

From this point of view, denying the right to dispose of one's own body by will or similar testamentary instruments (like on a donor registration system, for example) seems contrary to the principle established in *Re JS*; which ultimately sought to identify the person in the best position to make post-mortem determinations on behalf of the deceased.[57] Chapter 2 of this thesis will examine this notion further in the context of potential problems with Canada's current donation frameworks. One of those problems, as we will see, is that the frameworks violate individual autonomy. In that chapter, I pose the intestacy and wills parallel to highlight the unprincipled nature of the current donation systems and to illuminate the connection that post-mortem donation has to

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[52] *Williams*, *supra* note 40.
[53] *Re JS*, *supra* note 50 at 48.
[54] *Ibid* at 37.
[55] *Ibid* at 47.
[56] The scope of this thesis does not include hypothesizing as to whether a cryogenically frozen body takes on the same proprietary nature as that of frozen sperm as determined in *Yearworth*, s*upra* note 4, or *Lam* (2013 BCSC), *supra* note 3; aff'd *Lam* (2015 BCCA), *supra* note 3, or perhaps as that of a the preserved fetus as determined in *Doodeward*, *supra* note 41. It is clear that courts determine property interests in human bodies and body parts narrowly and on a case-by-case basis. The nature of a cryogenically preserved body is apt to carve out a new exception to the rule that there is "no ownership in a human corpse" since this preserved version of a human body is unlike those that the courts have considered to date. For example, since a property interest vests in the frozen sperm's donor, to whom would the property interest in a cryogenically frozen body vest? Would it vest in the deceased's closest representative or would it vest in the company that conducted the preservation? What about in 200 years when all relatives of the cryogenically frozen body are gone? These questions fall beyond the scope of this thesis, but they are undoubtedly forthcoming issues for the courts to determine.
[57] The Court in *Re JS*, *supra* note 50 at para 37, acknowledges that this decision may encourage other pre-death applications and notes that it will deal with those on a case-by case basis.

property law, which Chapter 3 discusses in greater detail. Before we get there, though, it will be helpful to have a better understanding of how Canada's current donation frameworks came to be. Accordingly, what follows the above overview of the common law is the historical development and legislative history of donation statutes in Canada.

1.2 Historical Development of Canada's Donation Legislation

Three waves of legislation led us to our current donation framework, and the first wave can be traced back to the mid-nineteenth century.[58] In 1849, legislation regarding human tissue arose in response to the increased demand for anatomical subjects and cadaveric research at Canadian medical schools.[59] Around that time, legislation was adopted on the principle that unclaimed bodies, either publicly exposed or left in public institutions like hospitals or prisons, should be used for teaching purposes at medical schools.[60] Since then, tissue transfer legislation has included a "bequeathal principle", which authorizes people to "donate their bodies to medical science".[61] Stemming from that earliest wave of human tissue legislation, approximately 600 bodies are supplied annually to medical schools under today's provincial anatomy acts or statutes alike.[62]

The second wave of human tissue legislation began a century later, in the 1950s, with the introduction of corneal transplant statutes that allowed for the treatment of various forms of blindness. In 1959, the Canadian Conference of Commissioners on Uniform Legislation (now the Uniform Law Conference of Canada or ULCC),[63] proposed a *Uniform Cornea Transplant Act*,[64]

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[58] Law Reform Commission of Canada, *Procurement and Transfer of Human Tissues and Organs* (Ottawa: Minister of Supply and Services Canada, 1992) at 127, online: <https://ia800809.us.archive.org/10/items/procurementtrans00lawr/procurementtrans00lawr.pdf> [LRCC].

[59] *Ibid* at 129. See also von Tigerstrom, *supra* note 2 at S9.

[60] LRCC, *supra* note 58 at 128. The early practice of transferring unclaimed bodies to medical schools has raised the question as to whether some of the dead were a public property. See LRCC, *supra* note 58 at 128.

[61] *Ibid* at 129. See also Conference of Commissioners on Uniformity of Legislation in Canada, *Proceedings of the Fifty-Third Annual Meeting of the Conference of Commissioners on Uniformity of Legislation in Canada* (1971) at Appendix I, s 4, online: Uniform Law Conference of Canada: <http://www.ulcc.ca/images/stories/Past_Proceedings_PDF/1971ULCC0053.pdf> [*1971 Uniform Act*].

[62] LRCC, *supra* note 58 at 129. Some (but not all) Canadian provinces have anatomy acts that specifically facilitate the study of anatomical research. The provinces with anatomy acts are Nova Scotia (*Anatomy Act*, RSNS 1989, c 13), British Columbia (*Anatomy Act*, RSBC 1996, c 13), Manitoba (*The Anatomy Act*, CCSM c A80), Ontario (*Anatomy Act*, RSO 1990, c A.21), and New Brunswick (*Anatomy Act*, RSNB 2011, c 110). Saskatchewan did have an anatomy act (*The Anatomy Act*, RSS 1978, c A-19 [repealed]), but it was repealed and replaced by the *Public Health Act*, 1994, SS 1994, c P-37.1.

[63] The purpose of the ULCC was addressed by President W.F. Bowker (as he then was) in his 1965 address to the Conference: "Today the development of national communications, nation-wide businesses and a mobile population make [the need for Uniform Acts] much more acute than it was during World War I. Besides, there are divisive tendencies that should be balanced by forces that will bring us together. As we approach the Centenary of Confederation, is it too fanciful to suggest that this Conference can help to secure a more united Canada? See Conference of Commissioners on Uniformity of Legislation in Canada, *Proceedings of the Forty-Seventh Annual Meeting of the Conference of Commissioners on Uniformity of Legislation in Canada* (Conference of Commissioners on Uniformity of Legislation in Canada, 1965) at 22-23, online: Uniform Law Conference of Canada: <http://www.ulcc.ca/images/stories/Past_Proceedings_PDF/1965ULCC0047.pdf> [*1965 Uniform Act*].

[64] *Uniform Cornea Transplant Act* (Model Act) in *1959 Proceedings of the Forty-first Annual Meeting of the Conference of Commissioners on Uniformity of Legislation in Canada* (Victoria, B.C.: The Conference, 1959) at 77 ["*1959 Uniform Cornea Transplant Act*"].

which was eventually adopted by eight provinces and two territories.[65] This legislation introduced a "donation principle" that enabled people to donate eyes after death.[66] Under the proposed 1959 *Uniform Cornea Transplant Act* we also see the donation principle extend to next-of-kin or someone in lawful possession of the body (the "possessor"), so that even if a person's intent to donate was unknown, their family or possessor could consent on the deceased's behalf.[67] Thus, the first trace of the substitute decision-making is introduced quite early on in the development of Canadian human tissue legislation, making its debut alongside that of the "donation principle".

The third wave of legislative reform was initiated by the "organ transplant age", a period between the early 1950s and 60s when people realized that kidney transplantation was a beneficial treatment for end-stage renal failure.[68] During this time, the ULCC developed a uniform statute within the *1965 Uniform Act* to deal with post-mortem donation of organs and tissue. The ULCC adopted uniform statutes on organ donation in 1965,[69] 1971,[70] and 1989 (revised in 1990).[71] The 1965 model established Canada's first donation framework to allow for the transplant of organs and tissue beyond just corneas. This early donation model was brief and contained provisions that dealt only with post-mortem organ and tissue donation.[72] It comprised donative provisions that seemed to empower the deceased with "binding and full authority" to decide whether their body and/or body parts would be donated for therapeutic purposes, for science, or not at all.[73] The 1965 model gave further effect to substitute decision-making by establishing an exception to the deceased's binding authority, mandating that people (i.e. doctors or donor organizations) shall not act on a donative consent where there is "reason to believe" that the deceased had later withdrawn that consent.[74] In such instances, the legislation empowered the deceased's relative or lawful possessor to determine whether the body/body parts would be donated. This so-called "substitute consent" or "substitute

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[65] LRCC, *supra* note 58 at 130.
[66] *Ibid* at 130. See also von Tigerstrom, *supra* note 2 at S9.
[67] *1959 Uniform Cornea Transplant Act*, *supra* note 64 at 77, s 4. See also LRCC, *supra* note 58 at 130.
[68] LRCC, *supra* note 58 at 130. One of the first Canadian provinces to introduce organ donation legislation was Ontario, replacing its *Cornea Transplant Act* with the H*uman Tissues Act* in 1963. See LRCC, *supra* note 58 at 131.
[69] *Human Tissue Gift Act* (Model Act) in *1965 Uniform Act*, *supra* note 63 at 104-106 (Appendix M). See also von Tigerstrom, *supra* note 2 at S10.
[70] *Human Tissue Gift Act* in *Proceedings of the Fifty-Third Annual Meeting of the Conference of Commissioners on Uniformity of Legislation in Canada* (Conference of Conference of Commissioners on Uniformity of Legislation in Canada, 1971) at 152-156 (Appendix I), online: Uniform Law Conference of Canada: <http://www.ulcc.ca/images/stories/Past_Proceedings_PDF/1971ULCC0053.pdf> [*1971 Uniform Act*]. See also von Tigerstrom, *supra* note 2 at S10.
[71] *Uniform Human Tissue Donation Act (1990)* in *Uniform Law Conference of Canada, Human Tissue Donation Act*, (1990), online ULCC <www.ulcc.ca/en/unofmr-acts-new-order/older-uniform-acts/440-josetta-1-en-gb/uniform-actsa/human-tissue-donation-act/284-human-tissue-donation-act-1990-draft> [*1990 Uniform Act*]. See also von Tigerstrom, *supra* note 2 at S10.
[72] *Human Tissue Gift Act* (Model Act) in *1965 Uniform Act*, *supra* note 63 at 104-106 (Appendix M). It is unclear why *only* post-mortem donation was entertained in this early uniform statute. The Alberta Commissioners that drafted the 1965 model noted that they hoped their draft would be accepted by all Canadian jurisdictions as the model *Cornea Transplant Act*. This suggests that they did not consider *inter vivos* donations since corneas could not be taken from living donors in the 1960s. See *1965 Uniform Act*, *ibid* at 63.
[73] *Human Tissue Gift Act* (Model Act) in *1965 Uniform Act*, *supra* note 63 at 104-106, (Appendix M), s 1(1)). Nunavut's statute is modeled on the original *1965 Uniform Act*. See *Nunavut Act*, *supra* note 1. See also von Tigerstrom, *supra* note 2 at S10. Hence, Nunavut's donation statute is nearly identical to the 1965 template, with some minor exceptions (for example, the *Nunavut Act* replaces the ULCC's 1965 proposed consenting age from 18 to 19, which is Nunavut's age of majority. See *Nunavut Act*, s 1.
[74] *Human Tissue Gift Act* (Model Act) in *1965 Uniform Act*, *supra* note 63 at 104-106, (Appendix M), s 1(2).

decision" became binding and full authority, but it too was subject to a near identical exception, capable of veto where there was "reason to believe" that the deceased would have objected to that substitute decision, or where there as an objection from another member of the same class of persons as the person who gave the substitute decision.[75]

Substitute decision-making has remained the same within uniform donation statutes since 1965, securing a spot in the ULCC's subsequent 1971 and 1990 models.[76] For nearly two decades, the *1971 Uniform Act* would serve as the model template for organ donation in Canada. During that time, 9 Canadian jurisdictions, including Saskatchewan, base their donation framework on the 1971 uniform model.[77] Today, all territorial and provincial organ donation statutes include the principles of donation and substitute decision-making,[78] both as elements that are seemingly unable to exist without the other.[79]

1.3 Canada's Donation Legislation Today

a) Case Study: Saskatchewan

Much like the common law, the legislative frameworks governing organ and tissue donation have evolved over time. For 40 years, Saskatchewan's organ and tissue donation was governed by *The Human Tissue Gift Act.*[80] However, on July 16, 2018 that statute was repealed and replaced by *The Human Tissue Gift Act, 2015* (the "*2015 Saskatchewan Act*").[81] Its enactment followed the provincial government's inquiry into improving the rate of organ and tissue donation in Saskatchewan, an inquiry that took place between May, 2016 through November, 2016.[82]

Like all provincial models, the *2015 Saskatchewan Act* requires consent to donate a person's organs and tissue. Consent, when given in accordance with the legislation, can authorize a body, bodily

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[75] *Ibid* at 104-06, (Appendix M), s 2(2).

[76] The *1971 Uniform Act*, *supra* note 70, also widened the scope of organ donation, adding in provisions that allowed for *inter vivos* donation. See von Tigerstrom, *supra* note 2 at S10.

[77] The jurisdictions of Saskatchewan, British Columbia, Manitoba, Ontario, Prince Edward Island, New Brunswick, Newfoundland and Labrador, Yukon and Québec base their donation models on the 1971 uniform framework, with modifications and updates in some cases. See Uniform Law Conference of Canada, "Table III – 2006: Uniform Acts adopted before 2000, Showing the Jurisdictions that Have Enacted Them in Whole or in Part, With or Without Modifications, or in Which Provisions Similar in Effect are in Force", online: ULCC <http://www.ulcc.ca/en/general-info-status/other-implementation-tables/2129-table-iii-pre-2000-unifonn-acts-enacted-by-statute> [ULCC, "Table III- 2006"]. See also von Tigerstrom, *supra* note 2 at S11 and footnote 42.

[78] These principles are commonly cited as "consent by person for use of body after death" and "consent by spouse or others for use of body after death", or some phrasing akin to that. See for example, *BC Act*, *supra* note 1 at ss 4(1), 5(1); *Manitoba Act*, *supra* note 1 at ss 2(1), 2(3), 3(1), 3(3); and *Ontario Act*, *supra* note 1 at ss 4(1), 5(2). The precise language within the sections dealing with post-mortem and substitute decisions tend to vary somewhat between jurisdictions. For example, some jurisdictions have placed restrictions on donations made by minors and on individuals that lack requisite capacity. See von Tigerstrom, *supra* note 2 at S12. These variations and others alike are largely attributed to the particular *Uniform Act* (1965, 1971 or 1990) that underpins a particular provincial or territorial donation act.

[79] See Chapter 2 of this thesis for further discussion of this point.

[80] *The Human Tissue Gift Act*, RSS 1978, c H-15 [repealed].

[81] *2015 Saskatchewan Act*, *supra* note 1.

[82] Saskatchewan, Legislative Assembly, Standing Committee on Human Services, "Inquiry into Organ and Tissue Donation: Second Report of the Twenty-Eighth Legislature" (28 November 2016) at 1. No significant changes were made to the provisions concerning consent to post-mortem donation and substitute decision-making. See *2015 Saskatchewan Act*, *supra* note 1, ss 7, 9.

tissue or body parts to be used after death "for the purposes of transplant, medical education or scientific research."[83] However, consent cannot authorize selling, buying or otherwise dealing in bodies, bodily tissue or body parts (other than blood or blood constituents).[84] Under s 18, contravention of any provision therein is an offence punishable by a fine up to $100,000 and/or by imprisonment for a term not exceeding six months.[85]

Section 7(1) of the *2015 Saskatchewan Act* states that a person may consent to post-mortem donations by signing a written instruction, or orally in the presence of two or more witnesses during last illness.[86] Upon death, both written and oral forms of consent become binding and are to be full authority to use the body, bodily tissue and body parts for the purposes specified in the deceased's consent, except where there is "reason to believe" that the consent was subsequently withdrawn.[87] In that case, or where consent has not been or cannot be given, a substitute decision-maker (i.e. the deceased's nearest relative) may consent to donation on the deceased's behalf.[88] This substitute decision is deemed binding and is to be full authority, except where there is "actual knowledge" that the deceased would have objected to the substitute decision, or where there is an objection by a person of the "same or closer relationship" to the deceased.[89]

The abovementioned overview summarizes the current post-mortem organ donation process in Saskatchewan and, by no coincidence, also summarizes the post-mortem donation structure in most other Canadian jurisdictions. Substitute decision-making provisions have remained virtually unchanged across Canadian jurisdictions, without any significant variations from the *1965 Uniform Act*, except for the provinces of Alberta and more recently Nova Scotia, which have taken the most notable derogation from that uniform standard.

a) Case Study: Alberta

Alberta's *Human Tissue and Organ Donation Act* (the "*Alberta Act*") came into force on August 1, 2009.[90] Although modeled on the *1990 Uniform Act*,[91] the *Alberta Act* adds a "mandatory consideration principle" and provisions concerning their online registry that enable consent to be recorded online when a person applies for either a driver's licence or a provincial identification card.[92]

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[83] *2015 Saskatchewan Act*, *supra* note 1 at s 7(1).
[84] *Ibid* at s 17.
[85] *Ibid* at s 18(1).
[86] *Ibid* at s 7(1).
[87] *Ibid* at ss 7(3), 7(4).
[88] *Ibid* at s 10(1).
[89] *Ibid* at s 10(3).
[90] *Alberta Act*, *supra* note 1 at s 17.
[91] *1990 Uniform Act*, *supra* note 71. The *Northwest Territories Act*, *supra* note 1, is modeled on this 1990 framework.
[92] *Alberta Act*, *supra* note 1 at s 4.2(1) – 4.2(2). The *Alberta Act* also authorizes the Alberta Government to collect and transmit this consent to other Government registries. See *Alberta Act*, s 4.3. Moreover, the *Alberta Act* mandates the Registrar of Motor Vehicle Services and the Minister responsible for issuing identification cards to ask the applicant (for the license or identification card) whether he or she consents to donating his or her organs and tissue post mortem. See *Alberta Act*, s 4.2(1)(a), (b). British Columbia, Manitoba and Ontario also have online donation registries but the organ donation legislation in those provinces predates the web-based developments and therefore those provincial statutes do not include provisions concerning the online registries. For online registries, see Provincial Health Services Authority, "BC Transplant", online: <http://www.transplant.bc.ca/our-services/organ-donor-registry/register-your-decision>; Transplant Manitoba, "Donation Programs", online:

The mandatory consideration process requires Albertan medical practitioners to "consider and document" whether a deceased's organs and tissue are medically suitable for transplant.[93] If they are suitable, the medical practitioner must notify a donation organization.[94] At that point, if consent to donation is unknown, a "required request principle" mandates the donation organization to seek consent from the deceased's next of kin,[95] and the next of kin's substitute decision becomes binding and is to be full authority, unless there is "personal knowledge" that the donor would have objected to it or where a person in the same class would refuse to give a consent.[96]

On the other hand, if a deceased's consent was previously recorded in the online registry, the *Alberta Act* mandates that a donation organization must not seek a substitute decision from the deceased's next of kin.[97] In this way, one of the aims of the online registry is to ensure that the deceased's donative wishes will be honored, especially where those wishes conflict with the views of a deceased's next of kin.[98] However, much like the uniform models before it, Alberta's donation structure preserves the role of substitute decision-making; providing an override power to *any* previously recorded consent, including consent documented in the online registry, by prohibiting anyone from acting on a prior given consent if they have "personal knowledge" that the donor would have objected to the donation proceeding.[99]

Alberta's online registry and mandatory consideration requirement are the first of their kind among the Canadian jurisdictions.[100] However, its donation framework has been slow to realize the Alberta

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<http://www.transplantmanitoba.ca/decide/sign-up-for-life>; and Ontario, "Ontario Organ and Tissue Donor Registration", online: <https://www.ontario.ca/page/organ-and-tissue-donor-registration?utm_source=so&utm_medium=keyword&utm_campaign=original>. See also Sonya Norris, "Organ Donation and Transplantation in Canada (Background Paper)" Publication No 2011-113-E (Ottawa: Library of Parliament, 2011; revised 2014) at 12 [Norris]; Jocelyn Downie *et al.*, "Pre-mortem transplantation optimizing interventions: the legal status of consent" (2008) 55:7 Canadian Journal of Anesthesia 458-469.

[93] *Alberta Act*, *supra* note 1 at s 7(1).

[94] *Ibid* at s 7(2).

[95] New Brunswick and Nova Scotia also instituted required request. In New Brunswick, people applying for the Provincial Medicare Card are asked whether they wish to donate their organs and tissue and must indicate their donative intent to Service New Brunswick, at which point a new Medicare Card will be issued with a "D" symbol, signifying that the person is a donor. See Horizon Health Network, "NB Organ and Tissue Program", online: <https://en.horizonnb.ca/home/facilities-and-services/provincial-programs/nb-organ-and-tissue-program.aspx>. See also Norris, *supra* note 92 at 12. Under the *Alberta Act*, *supra* note 1 at s 7(4)(a)(i) the donation organization must not seek consent from next of kin if the medical practitioner advises that he or she has personal knowledge that the deceased would have refused to the donation.

[96] *Alberta Act*, *supra* note 1 at ss 4(2) – 4(3). With regard to the term "same class", the *Alberta Act* states a person in one of the following classes and in the following order of priority may give substitute consent: (a) the spouse or adult interdependent partner of the person if they are not estranged; (b) an adult child of the person; (c) a parent or guardian of the person; (d) an adult sibling of the person; and (e) any other adult next of kin of the person (s 4(2)). Moreover, the *Alberta Act* states that a person shall not seek or give consent under s 4(2) if he or she has personal knowledge of (a) a person in a higher priority class is readily available to provide a consent; (b) a person in the same class would refuse to give a consent; or (c) the donor would have refused to give a consent (s 4(3)).

[97] *Ibid* at s 7(4)(b).

[98] Erin Nelson, "Alberta's New Organ and Tissue Donation Law: The Human Tissue and Organ Donation Act" (2010) 18:2 Health L Rev 5 at 5-6 [Nelson].

[99] *Alberta Act*, *supra* note 1 at s 8(3)(a).

[100] Other jurisdictions in Canada maintain databases of "intended donors" (for example, British Columbia, Nova Scotia and Ontario), but these databases are not mandated by the human organ and tissue donation legislation in their respective jurisdiction. See Norris, *supra* note 92 at 10. See also Provincial Health Services Authority, "Live Life.

Government's claim that the 2006 revisions would increase the rate of potential donors to actual donors.[101] Moreover, the statistics neither support nor refute the notion that the 2006 legislative changes would ensure the deceased donor's wishes take precedence over those of the family, because the details concerning who ultimately made the donative decision is either not documented or not made available to the public.

Over the past decade, donation rates in Alberta have slowly but steadily increased. There were 52 deceased donors in 2015; 70 deceased donors in 2016; 81 deceased donors in 2017; and 71 deceased donors in 2018.[102] Although there was a decrease in donation between 2017 and 2018, the statistical trend over the last decade suggests that the 2006 amendments have contributed to an overall increase in the number of deceased patients being referred to organ procurement organizations as possible potential donors. But what the statistics do not tell us is the percentage of Albertans that register as donors while alive, or even how many Albertans are currently registered on the 2006 system.

In some combination, Alberta's online registry and mandated referral program appear to have increased donation rates, though only slightly. In reviewing Alberta's transplant waitlist statistics in recent years, it is obvious that there is still a great need for increased donations. In 2017, there were 627 patients waiting for a single transplant in Alberta and another 13 patients waiting for combination transplants.[103] That same year, 35 Albertans died waiting for transplants and 61 others withdrew from the waitlist; the latter meaning that they either improved, opted to be removed, or were too ill to be kept on the list.[104] With 627 people awaiting a transplant in 2017, and 25,532 deaths in Alberta that same year, the 81 deceased donors that same year left much to be desired.[105]

While the Alberta framework seems to do a better job at recognizing individual autonomy via online registration opportunities and attempts to respond to the public's need for increased donation rates via the mandated referral program, it continues to fall short of making truly impactful change. Registering consent online is no doubt helpful for organizing and tracking consent, but the framework still falls short of mandating consent as full and binding authority and could quite obviously do more to make potential donors actual donors. A recent push for further reform to Alberta's donation system[106] – one that is considering a presumed consent model like the newly

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Pass it on.", online: <http://www.transplant.bc.ca/>; Nova Scotia Health, "Give a Legacy of Life", online <http://www.legacyoflife.ns.ca/>; Trillium Gift of Life Network, "Organ and tissue donation saves lives", online: <https://www.giftoflife.on.ca/en/>.

[101] Nelson, *supra* note 98 at 11.

[102] These statistics include cardiorespiratory and neurologically determined deaths. See Canadian Institute for Health Information, *e-Statistics Report on Transplant, Waiting List and Donor Statistics: 2018 Cumulative Report, January 1 to December 31,* online: <https://www.cihi.ca/en/e-statistics-on-organ-transplants-waiting-lists-and-donors> at Table 4 [CIHI 2018 Cumulative Report].

[103] Canadian Institute of Health Information, *e-Statistics Report on Transplant, Waiting List and Donor Statistics: 2017 Cumulative Report*, online: <https://www.cihi.ca/en/e-statistics-on-organ-transplants-waiting-lists-and-donors> at Table 2A, Table 2B.

[104] *Ibid* at Table 2C.

[105]Statistics Canada, "Death and mortality rated, by age group (Alberta): Table 13-10-0710-01", online: <https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1310071001&pickMembers%5B0%5D=1.10&pickMembers%5B1%5D=3.1>.

[106] See Bill 205, *Human Tissue and Organ Donation (Presumed Consent) Amendment Act, 2019*, 1st Sess, 30th Leg, Alberta, 2019, online: <https://docs.assembly.ab.ca/LADDAR_files/docs/bills/bill/legislature_30/session_1/20190521_bill-205.pdf> [Bill

enacted system in Nova Scotia – is quite telling of the continued disappointment brought by the 2006 registration system. With this in mind, I turn now to Nova Scotia's new presumed consent legislation, which aims to bridge the gap between potential and actual donors.

b) Case Study: Nova Scotia

On January 18, 2021, Nova Scotia became the first jurisdiction in North America to enact presumed consent legislation.[107] Under the new legislation, individuals record consents and refusals in a registry.[108] Those who do not register their consent or refusal are "deemed to consent to [their] organs and tissues being used for transplantation activities."[109] The presumption of consent is to be "full authority for transplantation activities,"[110] unless the deceased lacked capacity to make a decision about donating "for a significant period before dying,"[111] or if the deceased was not a resident of Nova Scotia for 12 months immediately prior to death,[112] or if the deceased was under the age of majority.[113]

In keeping with all other Canadian jurisdictions, Nova Scotia's presumed consent legislation will continue to empower the substitute decision-maker to consent or refuse consent if they have "information that would lead a reasonable person to conclude that the deceased would have made a different decision respecting donation after death than the decision recorded in the registry" or presumed under the legislation.[114] Alberta's proposed presumed consent legislation has a near-identical provision at s 4.01(2)(c).[115] Moreover, s 32 of the *Nova Scotia Act (2019)* mandates that "[n]o person shall give a consent or refusal under this Act if the person has personal knowledge that the individual for whom the consent or refusal is given would have made a different decision."[116]

The new legislation also maintains the classic exception to the mandate that consent is to be binding and full authority. Section 31 of the new Act will provide that "[n]o person shall act on a consent given or deemed to be given under this Act if the person has knowledge (a) that the donor

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205]. See also: Alberta, Legislative Assembly, *Hansard*, 30th Leg, 1st Sess, No 40 (6 November 2019) at 2223 (first reading passed), online: <https://docs.assembly.ab.ca/LADDAR_files/docs/hansards/han/legislature_30/session_1/20191106_1330_01_han.pdf#page=15)>.

[107] *Nova Scotia Act (2019)*, *supra* note 1.

[108] *Ibid* at s 7. However, pursuant to s 21(1), "[c]onsent to donate organs does not imply consent to pre-death transplantation optimizing interventions." The legislation defines "pre-death transplantation optimizing interventions" at s 2(s) as "interventions that are performed on a person before the person's death for the purpose of optimizing the chances of a successful transplantation." Consent to pre-death transplantation optimizing interventions must be voluntary and informed, and must be in writing or orally in the presence of at least two witnesses. Where the individual lacks capacity and consent has not been given, a substitute decision-maker is empowered to consent in accordance with s 22(3).

[109] *Ibid* at s 11(1). However, per s 22(1), "a deemed consent under Section 11 does not include consent to donation after death for scientific research or educational purposes.

[110] *Ibid* at s 11(2).

[111] *Ibid* at s 12(1).

[112] *Ibid* at s 13(1).

[113] *Ibid* at s 14(1).

[114] *Ibid* at s 15(1). For the order of priority of substitute decision-makers under Nova Scotia's presumed consent legislation see *ibid* at s 6.

[115] Bill 205, *supra* note 106 at s 4.01(2)(c).

[116] *Nova Scotia Act (2019)*, *supra* note 1 at s 32.

subsequently withdrew the consent; or (b) of an objection by the donor."[117] Similarly, Alberta's proposed presumed consent legislation states that consent will be presumed and organs and tissue will be donated for transplantation where a person dies and no donation decision has been made before their death.[118] However, the legislation goes on to state that a person is not considered to have agreed to a post-mortem donation if information is provided "that would lead a reasonable person to conclude that, if the deceased person had made a decision, they would have decided to refuse to donate in accordance with [the presumed consent provision].[119]

These might seem like wise provisions to include, but I would argue they are apt to carry more weight in procurement practices than what appears to be intended by the new legislated provisions. For example, if the exception under s 31 (Nova Scotia) or s 4.01(2)(c) (Alberta) are interpreted and applied like the exceptions under the current opt-in frameworks, medical professionals and donation organizations are going to continue seeking validation of the donor's previously recorded consent or the presumption of consent with next of kin. The Alberta Government and Alberta Health Services' website, "MyHealth Alberta", confirms that even where an individual has given consent to donating, "[a] family will be asked to sign a consent form saying they have been informed about, and agree with, the donation process, even if the person that died has signed the back of his or her healthcare card or registered online."[120] While the Alberta Government and Health Services agree that "[t]he decision to donate is a personal one" they also note that "…family helps make decisions about donating."[121] The MyHealth Alberta website also notes that "[r]egistering in the Alberta Organ and Tissue Donation Registry is an important way to communicate your wishes to the medical team,"[122] which in my view suggests the main role of the registration system is to communicate a person's intention to donate, but not necessarily to record one's binding, legal consent.

Nova Scotia's presumed consent legislation is undoubtedly the first radical reform to any donation framework in Canada and it is perhaps also the most promising for effecting a meaningful increase in organ and tissue donation. One of the aims of Nova Scotia's presumed consent law is to translate registrations (including presumed registrations) into actual donations.[123] In this way, it appears that one of the leading motivations for the presumed consent law is increasing donations. However, Nova Scotia's Premier, Hon. Stephen McNeil, believes the presumed consent clause will change the conversation between medical professionals and the deceased's family, to the effect that it will help increase donation rates.[124] According to Premier McNeil, through the presumed consent system, doctors will no longer be asking the family if the deceased is an organ donor. Rather, the

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[117] *Ibid* at s 31.
[118] Bill 205, *supra* note 106 at s 4.01(1).
[119] *Ibid* at s 4.01(2)(c)
[120] My Health Alberta, "Organ and Tissue Donation in Alberta", online: <https://myhealth.alberta.ca/alberta/Pages/organ-and-tissue-donation-faqs.aspx>.
[121] *Ibid*.
[122] *Ibid*. For further commentary on procurement trends, see Blair Bigham, "One in five willing organ donors in Ontario have their wishes vetoed by family – and doctors don't argue" (25 November 2016), online: *National Post* <http://news.nationalpost.com/news/one-in-five-willing-organ-donors-in-ontario-have-their-wishes-vetoed-by-family-and-doctors-dont-argue>. Blair Bigham is a resident doctor at McMaster University.
[123] Nova Scotia, House of Assembly, *Debates and Proceedings*, 63rd Assembly, 2nd Sess (4 April, 2019), <online: https://nslegislature.ca/legislative-business/hansard-debates/assembly-63-session-2/house_19apr04#HPage2889> at 2889 [Nova Scotia, April 2019 *Debates and Proceedings*].
[124] *Ibid*.

Premier believes that, instead, doctors can now say, "all of us are organ donors and we want to know whether you want to fulfill the wishes of your loved one," and this conversation is key to solving the organ donation problem, according to Premier McNeil.[125]

Thus, while the principal motivation of the presumed consent law appears to be increasing donation rates, it also seems another motivation is to get the family on board with the post-mortem organ donation, as if that should and will continue to play a key role in the post-mortem donation process. There seems to be a belief that increased donation rates will result from aiming the law at families and their conversation with doctors. This belief suggests that governments are not considering that increased donation rates can happen in a respectful, fair, and legal way without the role of the family at the centre of the process. It is as if there is an attitude across governments and organ donation agencies of 'we can't have one (being increased donation rates) without the other (being the families on board with donation), and in my view this is a flawed foundation to expect a successful donation system to grow from.

The presumed consent law came into force on January 18, 2021. Practically speaking, it is too soon to tell how this conversation will affect day-to-day procurement practices. In situations where the presumption of consent is engaged (i.e. the deceased did not opt out), and the family exhibits uncertainty about donation, will medical professionals move forward with the procurement? To rebut the presumption of consent, will it be enough for the family to say that the deceased donor *could* have changed his or her mind about donation? Section 15(1) of the *Nova Scotia Act (2019)* provides:

> 15(1) Where a substitute decision-maker provides information that would lead a reasonable person to conclude that an individual would have made a different decision respecting donation after death than the decision recorded in the Registry or deemed under Section 11 [the presumed consent provision], the substitute decision-maker may consent or refuse on behalf of the individual in accordance with that information.[126]

We know third-party information is enough to invalidate the prior "binding" consent of a deceased under the current opt-in framework. As we examined earlier, MyHealth Alberta and the Saskatchewan Health Region are just two examples of government agencies that explicitly state the family will be asked about the deceased's wishes, even where legal consent was given prior to death. There seems to be a very low threshold for the 'type' of information capable of invalidating a deceased's prior given consent, and it can be as informal as family dissenting to organ donation. I have not uncovered any sources or case studies that suggest a higher threshold of evidence has been required before a deceased's prior given consent is rendered invalid. It is not difficult to imagine that the same type of 'low threshold information' currently accepted under the opt-in frameworks will also be accepted under s 15(1) of Nova Scotia's presumed consent law, but only time will tell.

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[125] *Ibid*.
[126] *Nova Scotia Act (2019)*, *supra* note 1 at s 15(1).

Conclusion

As we have seen, there seems to be only so much that provinces are willing to reform under an opt-in donation model, and registries and mandatory consideration principles seem to be the extent of those reforms. Unfortunately, the success of any opt-in framework is limited by its heavy dependence on the altruism of donors and substitute decision-makers. As we saw, Saskatchewan has yet to institute any sort of reform and although Alberta has made changes aimed at ensuring a deceased's donative intent takes precedence over the next of kin's wishes,[127] tracking prior recorded consent through the online registry is simply not enough to protect donor autonomy. And as we saw, identifying medically viable donors through a mandatory consideration requirement has not led to a meaningful increase in organ and tissue donation.[128] Hence Alberta is now seeking to replace that with a presumed consent framework of some sort.

In Nova Scotia, the presumed consent clause appears to be aimed largely at the concerns and feelings of the deceased's next of kin. Much like the opt-in frameworks across the rest of Canada, Nova Scotia's new legislation is ripe to contravene the individual's autonomy to make a binding decision about organ donation, and not have that decision easily invalidated by family who disagree or by facilitating the procurement practice of having family 'consent' to the deceased's prior given consent. With a continued focus on family, the presumed consent system may very well fall short of the expectations it carries for increasing transplants, as once again the system responsible for establishing donations may rely far too much on substitute decision-making. In the chapter that follows, I will explore how the principles of public policy and individual autonomy are offended under the existing opt-in frameworks. These transgressions can and will endure under contemporary presumed consent systems if substitute decision-makers are empowered to hold the same authority as they carry under the opt-in models.

[127] Alberta, Legislative Assembly, *Hansard*, 26th Leg, 2nd Sess, (25 April 2006) at p 1050.
[128] Nelson, *supra* note 98 at 11. See also *Alberta Act*, *supra* note 1 at s 8(3)(a).

CHAPTER 2
Potential Problems with the Current Donation Model

Canada's opt-in organ donation model is broken. Revisiting the statistics of our case study's jurisdiction, we must remind ourselves that there were 97 Saskatchewan patients waiting for a transplant in 2017 and one reported death of a patient awaiting a transplant.[1] In that same year, there were 9,450 deaths recorded in the province.[2] Of those residents who died, only 17 became organ donors. Some may wonder how this issue concerns property law, but in my view the more accurate query is '*why isn't this a property law issue?*'

Is the current donation model to blame for low donation rates? Some may argue that low donation rates are simply the unfortunate consequence of a generalized provincial attitude towards organ donation, and that the majority of the people in Saskatchewan lean further against organ donation than they are in favour of it, hence the low donation rates. Without citing to a source, the Saskatchewan Health Authority (SHA) states on its website that "[o]nly a small portion of individuals die in such a way that makes organ donation possible – approximately 5 percent of all deaths."[3] Therefore, if we look at recent donation records, we can see that in the 2015 example, statistics show that of the estimated 470 people who died in Saskatchewan under circumstances that made organ donation clinically viable,[4] only 10 people became post-mortem donors.[5] Thus, of the 470 "could-be" donors, 460 people died without having any of their organs or tissue donated. This pool of deceased people either chose not to donate, failed to indicate donative wishes during their life or had their donative wishes reversed.

What kind of death makes organ donation clinically viable? Section 13(1) of *The Human Tissue Gift Act, 2015* states that, for the purposes of a post-mortem transplant, "the fact of death must be determined in accordance with accepted health care provider practice."[6] The legislation falls short of defining death for the purposes of post-mortem donation and in doing so it allows for flexibility with respect to determining death for the purposes of facilitating post-mortem organ procurements.

The SHA's statistic that only 5 percent of all deaths allow for post-mortem organ donation is likely based on "heart-beating brain death" or "HBD".[7] Also known as "brain death donation", HBD is a

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[1] Canadian Institute of Health Information, *e-Statistics Report on Transplant, Waiting List and Donor Statistics: 2017 Cumulative Report (January 1 to December 31)*, online: <https://www.cihi.ca/en/e-statistics-on-organ-transplants-waiting-lists-and-donors> [CIHI, 2017 Cumulative Report] at Table 2A, Table 2B, Table 2C.

[2] Statistics Canada, Death and mortality rates, by age group (Saskatchewan), online: <https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1310071001&pickMembers%5B0%5D=1.9&pickMembers%5B1%5D=3.1>.

[3] Saskatchewan Health Authority, "About Donation", online: <https://www.saskhealthauthority.ca/Services-Locations/organ-tissue-donation/Pages/AboutDonation.aspx> [SHA, "About Donation"].

[4] In 2015, 4,394 people died in Saskatchewan, and 5% of that number is 469.7. See Statistics Canada, "Death and mortality rates, by age group (Saskatchewan): Table 13-10-0710-01", online: <https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1310071001&pickMembers%5B0%5D=1.9&pickMembers%5B1%5D=3.1>.

[5] Canadian Institute for Health Information, *e-Statistics Report on Transplant, Waiting List and Donor Statistics: 2015 Cumulative Report (January 1 to December 31)*, online: <https://www.cihi.ca/en/e-statistics-on-organ-transplants-waiting-lists-and-donors> at Table 4.

[6] *The Human Tissue Gift Act, 2015*, SS 2015 c H-15.1 s 13(1) [*2015 Saskatchewan Act*].

[7] D Gardiner & R Sparrow, "Not dead yet: Controlled non-heart beating donation, consent and the dead donor rule" (2010) 19:17 Camb Q Healthcare Ethics 17 at 17.

procurement practice where organs become available when patients are declared brain dead but still have a beating heart and ventilating lungs.[8] In medical practice, a principle known as the "dead donor rule" or "DDR" represents the ethical standard that "organ donors must be dead before vital organs are removed."[9] In other words, the patient must be dead before organs are procured, rather than being killed by or for the organ donation. However, as most post-mortem donation statistics show, there is a shortfall in heart-beating brain death donors in Canada. Therefore, in response to the shortfall in clinically viable post-mortem donations, many hospitals have begun using the "non-heart-beating-organ donation" (NHBD) protocol, also referred to as "donation after cardiac death" (or "DCD").[10] Coupled with brain death donations, the DCD protocol is widely used across Canada and the United States, and is said to have helped increase the number of post-mortem donors by over 25 percent in Ontario.[11]

In DCD procurement, the patient need not necessarily be brain dead, but their heart has to have stopped beating for at least five minutes before organs can be removed.[12] The window of opportunity to procure organs following cardiac death is much narrower than brain death procurements because organs are deprived of oxygenated blood when circulation stops, and this can damage the organs and tissue. While time is of the essence in DCD cases, procurement must also "not occur so soon [after the heart stops] that the donor is not yet dead,"[13] otherwise the dead donor rule is at risk of violation.

If we consider that 9,450 people died in Saskatchewan in 2017[14], we must acknowledge that death in all of those cases was either declared after the heart stopped beating or at the point where brain death was pronounced. Organ procurement is available and accepted in either type of death scenario; however, only one DCD procurement took place in Saskatchewan in 2015 and 2016, and there were no DCD procurements in 2017.[15] The SHA's statistic that 'transplants are only medically feasible in approximately 5 percent of all deaths' would mean that post-mortem organ transplantation was viable for approximately 472 deceased individuals in 2017 (5 percent of Saskatchewan deaths that year), but in reality only 25 became post-mortem donors that year.[16]

This trend is less likely to be a symptom of unsuitable donors or lack of consent and more so a question of capacity in the healthcare system. Afterall, Saskatchewan's 2016 Legislative Committee Report stated that "…adequately resourced support systems need to be in place and staff need to be trained to move donations through the system quickly. Operating rooms need to be made available for transplants as well as for emergencies."[17] Lack of evaluations and measurements

[8] See Robert M. Sade, M.D., "Brain Death, Cardiac Death, and the Dead Donor Rule" (2011) 107:4 J S C Med Assoc 146 [Sade].
[9] *Ibid* at 146.
[10] Tom Blackwell, "'Dead-donor' rule dangerously misleading, experts say" (27 October 2011) online: *National Post* <https://nationalpost.com/news/canada/dead-donor-rule-dangerously-misleading-experts-say> [Blackwell].
[11] *Ibid*. See also Don Marquis, "Are DCD Donors Dead?" (2010) 40:3 Hastings Centre Report 24 [Marquis].
[12] Blackwell, *supra* note 10.
[13] Marquis, *supra* note 11.
[14] Statistics Canada, "Deaths, by place of death (hospital or non-hospital): Table 13-10-0715-01", online: <https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1310071501&pickMembers%5B0%5D=1.9>.
[15] CIHI, 2017 Cumulative Report, *supra* note 1 at Table 4.
[16] *Ibid* at Table 1A.
[17] Saskatchewan, Legislative Assembly, Standing Committee on Human Services, *Inquiry into Organ and Tissue Donation* in *Second Report of the Twenty-Eighth Legislature*, 28 November 2016 at 17.

under the current donation framework makes it difficult to identify the root causes of these poor donation trends. What is clear is that the statistics raise questions about whether there is a serious flaw in the organ donation program and in the law enabling the framework. As this thesis will show, law reform is going to be necessary in order to deal with the issues that hinder the donation program's success.[18]

In Part 1 of this chapter, I focus on two key issues within Saskatchewan's current "opt-in" model. First, I suggest that the provincial framework is an attack on individual autonomy because it enables post-mortem procurement practices that rely almost exclusively on substitute decision-making, thus putting the family's interest first. Second, and relatedly, I argue that the current framework violates public policy by neglecting to implement a process that combats low provincial donation rates and lengthy transplant waitlists. In Part 2 of this chapter, I identify intestacy law and wills as well-developed areas of the law that work to oversee the disposal of property after death. As we will see, honouring the deceased's intention, maintaining social order and limiting waste are some of the public policy motivations that drive intestacy law and wills. By viewing organs and tissue through a property lens, we start to see an important parallel between these areas of law and organ donation, and this parallel promotes our understanding of how the current framework is failing and why it needs to be reformed.

2.1 Key Issues

a) Violation of Individual Autonomy

Autonomy has long been viewed as having an important role in the medical context, and its role is very much interwoven with the notion of consent. At common law, medical professionals must obtain a patient's consent before administering medical treatment to a patient.[19] Justice Cory of the Supreme Court of Canada explained the classic nexus between autonomy and consent in *Ciarlariello v Schacter*:[20]

> Every patient's right to bodily integrity encompasses the right to determine what medical procedures will be accepted and the extent to which they will be accepted. The right to decide what is to be done to one's own body includes the right to be free from medical treatment to which the individual does not consent. The requirement that disclosure be made to the patient is based on this concept of individual autonomy.[21]

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[18] Some critics of DCD procurement argue that removal of organs so soon after cardiac arrest is unethical because the donor is not known to be dead, at least insofar as the age-old dead donor rule standard applies. The crux of this argument relies on the fact that brain death is permanent since there is no known medical intervention that can bring a person back from brain death, whereas cardiac death is not permanent (and technically reversible) since the heart can continue to beat with medical intervention. On the other hand, supporters of the DCD procurement protocol argue that death is equal in instances of brain death and cardiac death because only when there is no intention to revive a patient's heart is cardiac death actually declared. In this way, cardiac death is often perceived to be *as* permanent, if not *more* permanent, than instances of brain death where there is no intention (or ability) to revive the patient's brain. For interesting discussion from both sides of this debate, see Marquis, *supra* note 11 and Sade, *supra* note 8.

[19] *Reibl v Hughes*, [1980] 2 SCC 880, [1980] 2 SCR 880; *Hopp v Lepp*, [1980] 2 SCR 192, [1980] SCJ No 57 (WL).

[20] *Ciarlariello v Schacter*, [1993] 2 SCR 119, 100 DLR (4th) 609. [*Ciarlariello*].

[21] *Ibid.*

The Supreme Court of Canada recently confirmed the common law requirement for informed consent, recognizing - as lower courts have - that informed consent is "rooted in the concepts of an individual's right to bodily integrity and respect for patient autonomy."[22] Canada's highest Court also notes that the "patient's autonomy interest" is "the right to decide what happens to one's body and one's life", noting also that this has "historically been viewed as trumping all other interests, including what physicians may think is in the patient's best interest."[23]

The common law has long recognized principles of informed consent, well before Cory J's remarks in *Ciarlariello*. Since at least 1914, it has recognized that doctors could be found to have committed assault or battery where they perform an operation without the patient's consent.[24] Still, despite informed consent's early recognition, it has been given inconsistent application throughout the years and, as a result, so too has the autonomous right to determine what will be done with one's own body.

For example, it was not until 1988 that women were finally recognized in law as having the right to choose to have an abortion.[25] With respect to autonomy, Justice Wilson made the following observation at page 171 of *R v Morgentaler*:[26]

> "[t]he right to "liberty" contained in s. 7 guarantees to every individual a degree of personal autonomy over important decisions intimately affecting his or her private life. Liberty in a free and democratic society does not require the state to approve such decisions but it does require the state to respect them. A woman's decision to terminate her pregnancy falls within this class of protected decisions. …It is not just a medical decision; it is a profound social and ethical one as well."

Moreover, it was not until 2015 that individuals who suffered from debilitating medical ailments were recognized as having the right to seek the assistance of physicians in order to end their life with dignity.[27] In *Carter v Canada (Attorney General)*[28], the Supreme Court of Canada revisited the matter of patient autonomy in medical decision-making. The Court reviewed its 2009 majority decision in *A.C. v Manitoba (Director of Child and Family Services)*[29] and reiterated:

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[22] *Cuthbertson v Rasouli*, 2013 SCC 53 at para 18, [2013] 3 SCR 341 [*Cuthbertson*]. See also *Fleming v Reid* (1991), 4 OR (3d) 74 (CA), 82 DLR (4th) 298.
[23] *Cuthbertson*, *supra* note 22 at para 19.
[24] *Schloendorff v New York Hospital*, (1914) 105 NE 92, cited in Jonathan Herring, *Medical Law and Ethics*, 6th ed (Oxford, United Kingdom: Oxford University Press, 2016) at 207. See also *Malette v Shulman* (1990), 72 OR (2d) 417 at 423, [1990] OJ No 450 (WL) [*Malette*]: "The right of a person to control his or her own body is a concept that has long been recognized at common law. The tort of battery has traditionally protected the interest in bodily scrutiny from unwanted physical interference. Basically, any intentional nonconsensual touching which is harmful or offensive to a person's reasonable sense of dignity is actionable. …Thus, as a matter of common law, a medical intervention in which a doctor touches the body of a patient would constitute a battery if the patient did not consent to the intervention."
[25] *R v Morgentaler* [1988] 1 SCR 30, [1988] SCJ No 1 (WL).
[26] *Ibid.*
[27] *Carter v Canada (Attorney General)*, 2015 SCC 5, [2015] 1 SCR 331 [*Carter*].
[28] *Ibid.*
[29] 2009 SCC 30, [2009] 2 SCR 181 [*A.C. v Manitoba*].

> "[The] right to "decide one's own fate" entitles adults to direct the course of their own medical care ([*A.C. v Manitoba*] para. 40): it is this principle that underlies the concept of "informed consent" and is protected by s. 7's guarantee of liberty and security of the person ([*A.C. v Manitoba*] para. 100)… the right of medical self-determination is not vitiated by the fact that serious risks or consequences, **including death**, may flow from the patient's decision. It is this same principle that is at work in the cases dealing with the right to refuse consent to medical treatment, or to demand that treatment be withdrawn or discontinued…"[30]

As these few examples illustrate, autonomy over one's own body has become increasingly recognized over time. Interestingly, the Supreme Court in *Carter* acknowledged that the possibility of death does not vitiate a person's right of medical self-determination. In my view, it should also follow that a person's decision to donate (or not to donate) his or her organs after death should be given the same level of respect and autonomy because the decision is ultimately an exercise of his or her right to medical self-determination, albeit only determinable once deceased.

Some might argue that there is a distinction to be made between autonomy to choose when and how to die (as outlined in *Carter*), versus choosing what happens to our bodies after death. To that I would say the distinction is not enough, in my view, to qualify post-mortem donation choices as some lower form of autonomy that in essence cannot bind. If the law is willing to recognize and respect choices concerning when and how we die and is also aiming to increase donation rates, why does it still treat legal consent to post-mortem donation as a lesser form of consent? Is it because of the risk that the procurement could offend family? Or is it possibly because the health care system is afraid of potentially obligating itself to facilitate high volumes of post-mortem transplants? In my opinion, whatever the reason, the distinction between these types of medical decisions is not enough to merit giving post-mortem donation choices less respect than decisions concerning when or how we die.

As the current law stands, substitute decision-making can always be employed (and is typically required) to determine or possibly veto a deceased's prior given consent to post-mortem donation. This deference to substitute decision-makers is offensive to donor autonomy. To those that say it is meaningless to talk about exercising autonomy after death or with respect to what will happen after one's death, I would remind them that examples of respect for autonomy are common in society and have been well-recognized and respected by law. We see examples of this every day in wills and I will illuminate these parallels later on in this chapter by exploring wills and intestacy laws further.

In the meantime, if we further consider the notion of medical self-determination, it is generally understood that even in situations where treatment is vital to a patient's survival, a doctor cannot veto the patient's demand to end treatment.[31] Forcing the procedure on a patient is both legally and morally wrong because of the principle of autonomy.[32] Moreover, under the common law, for

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[30] *Carter*, *supra* note 27 at 67 [emphasis added].
[31] *Cuthbertson*, *supra* note 22 at para 18.
[32] Herring, *supra* note 24 at 207. For more on the right to refuse consent or to discontinue treatment, see *Ciarlariello*, *supra* note 20; *Malette*, *supra* note 24, and *Nancy B. v Hôtel-Dieu de Québec*, (1992) 86 DLR (4th) 385 (Que SC), [1992] JQ No 1 (QL).

consent to be valid the patient must provide it voluntarily and the patient must be informed.[33] A patient is informed when the doctor has ensured that "the patient understands the nature of the procedure, its risks and benefits, and the availability of alternative treatments before making a decision about a course of treatment."[34]

In determining whether a risk necessitates explanation to a patient, the Supreme Court of Canada has advised that an objective approach should be taken.[35] In other words, a doctor should contemplate "whether a reasonable person in the patient's position would want to know the risk."[36] In the context of post-mortem organ donation, explanation of material risk is unnecessary since procurement takes place after death or brain death. Thus, death is a key factor that allows the consent process for post-mortem donations to be simpler than that which is employed for medical procedures.

As one may expect, the common law of consent is generally directed at patients that have the requisite capacity to make decisions concerning medical treatment.[37] A patient is said to have capacity when they have the ability to understand the "nature, purpose and consequences" of a particular form of treatment.[38] However, the traditional approach of initiating medical treatment by first obtaining informed consent meets challenges in situations where patients cannot understand the nature, purpose, and consequences of a doctor's proposed treatment.[39] As a general rule, when a patient lacks this sort of understanding, he or she does not exercise autonomy by consenting or refusing a particular medical treatment.[40] In other words, they are said to "lack capacity".

The common law of consent seems at odds with the version of consent employed in Saskatchewan's statutory provisions concerning post-mortem donation. Consent given prior to death and in accordance with the Act is to be binding and full authority,[41] unless the doctor has "reason to believe that it was subsequently withdrawn."[42] In the medical context, case law has dealt with the issue of withdrawn consent in circumstances involving living, and sometimes unconscious, patients.[43] In those circumstances, the common law holds that it is a question of fact as to whether a patient has withdrawn consent.[44] Whether a deceased patient has withdrawn consent to organ donation has yet to go to trial (i.e. there is no case law on this issue); however, donation agencies seem to have a moral or normative view that the final word on organ donation should rest with the deceased's family, regardless of the individual's capacity at the time of leaving legal consent. In my view, the end result is the same as treating a person as though they lacked capacity, which should signal a problem with the consent provisions of the statute. Although Saskatchewan's statute recognizes that a donor's consent is to be full and binding authority, consent given in accordance with the Act can always be replaced by the wishes of a substitute decision-maker.

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[33] *Cuthbertson*, *supra* note 22 at para 18.
[34] *Ibid.*
[35] *Ciarlariello*, *supra* note 20.
[36] *Ibid.*
[37] *Cuthbertson*, *supra* note 22 at para 19.
[38] *Ibid.*
[39] *Ibid* at para 20.
[40] *Malette*, *supra* note 24 at 423-424.
[41] *The Human Tissue and Gift Act*, RSS 1978 c H-15 [repealed], s 5(1) [*1978 Saskatchewan Act*].
[42] *Ibid* at s 5(3).
[43] For example, see: *Ciarlariello*, *supra* note 20.
[44] *Ibid*.

The futility of the statutory consent provisions is made especially obvious by the Saskatchewan Health Authority's (SHA) interpretation of the provincial organ donation statute. The SHA is a provincial agency responsible for overseeing the delivery of health services and programs across the province. It is accountable to the public, generally, and is governed by the Saskatchewan Health Authority Board of Directors, which is comprised of 10 members appointed for three-year terms by Saskatchewan's Minister of Health.[45] On its website, the SHA states that "[i]n Saskatchewan, organs and tissue will not be donated without your family or next-of-kin's consent" and it therefore encourages people to discuss their organ donation wishes with loved ones, because doing so will assist them in making "this important decision" on the deceased person's behalf.[46] As discussed in Chapter 1, this is similar to MyHealth Alberta's interpretation of their provincial statute, where family are asked to 'consent to the deceased's prior given consent'[47], regardless of whether it was made in accordance with the statute.

The SHA's interpretation of the provincial statute undermines any notion of personal consent, and this seems contrary to the underlying objectives of the consent provisions. The SHA's approach disregards the binding nature of prior consent, and relies solely on the override exception, which stipulates that personal consent to donation is binding and only subject to the override exception if there's reason to believe the deceased changed his or her mind. In this way, the SHA's approach appears to fly in the face of the personal consent provisions.

Defenders of the SHA's approach might argue that the "consent is binding authority exception" ultimately gives family the final decision-making power, and therefore persuading family of one's final wishes prior to death seems sensible. But is the deceased's prior given consent intended to be subordinate to the family's final decision-making power? Presumably not. If the objective is to give family the ultimate decision-making power, then why include any provisions at all for personally consenting to donation? If the only aim of the personal consent provisions is to establish a basis for family to work from in order to make the final decision, then the donation statute's legislative objective is far more offensive than the SHA's donation program. But I do not believe this is the intended application of the personal consent provisions. At some point between the legislation coming into force and its present application by the SHA, the principle of autonomy got lost.

Discussing wishes with loved ones and establishing next of kin as the vessel for a deceased's wishes is not a stable platform for recording consent. Simply put, family should not be the conduit of prior given consent and, although considered acceptable, family should also not be the main basis for determining the fate of a deceased's organs and tissue when consent was not given prior to death. Of course, authorizing next of kin as the ultimate decision-maker could have positive effects on people awaiting an organ transplant. For example, positive impacts are likely where a deceased did not consent to donation prior to death but where the next of kin authorizes the donation. On the

[45] Saskatchewan Health Authority, "Our Organization: Governance", online: <https://www.saskhealthauthority.ca/about/Pages/Governance.aspx>.
[46] Saskatchewan Health Authority, "Organ and Tissue Donation: Talk to Your Family", online: <https://www.saskhealthauthority.ca/Services-Locations/organ-tissue-donation/Pages/Talk-to-Your-Family.aspx> [SHA, "Talk to Your Family"].
[47] My Health Alberta, "Organ and Tissue Donation in Alberta", online: <https://myhealth.alberta.ca/alberta/Pages/organ-and-tissue-donation-faqs.aspx>. See also Maeghan Toews, "Evaluating the "family veto" of consent for organ donation" (2016) 188:17/18 CMAJ at E436.

other hand, negative impacts are just as likely where next of kin vetoes the deceased's prior given consent to donate.

Notwithstanding the opposite outcomes in the above scenarios, autonomy is at issue in both situations. Where a person dies without donative wishes, substitute decision-making that leads to donation is apt to benefit a handful of people; however, individual autonomy is still prone to violation (despite the public benefit) because the current model does not provide a secure platform for individuals to solidify their non-consenting instruction. Likewise, the current model fails to "codify" the consent of those that wish to donate, and in this way the provincial model violates what little autonomy it alleges to provide under the consent provisions of the Act.

Consent in the context of organ and tissue donation should be viewed as a protector of autonomy. In overlooking consent given in accordance with the Act, the province is violating the individual's autonomous right to decide what happens to his or her own body. Autonomous choice embodies the notion of individual freedom; freedom to control one's own destiny by "being able to decide how to live out [one's own perceived] version of the 'good life'.[48] In the context of post-mortem organ donation, a framework that respects individual autonomy would guarantee a deceased's prior consent. At the same time, that framework ought to impose a process that can identify and respect the autonomy of individuals that do not consent to post-mortem organ donation. Saskatchewan's current donation framework does neither of these two things.

Notwithstanding instances where the deceased provided sufficient consent prior to dying, the framework upholds and actually enforces a process of "re-determining" consent. The reason for this is largely because the law has distinguished between people who are competent to make decisions and those who are not.[49] The statutory provisions dealing with post-mortem donation treat the deceased as having lacked capacity to legally consent while alive, while the provisions dealing with *inter vivos* donation view the individual as fully competent and fit to consent to donation. As Professor Jonathan Herring so eloquently puts it, "fall on the side of competence and your right to autonomy requires your decision to be respected; fall on the side of incapacity and the decision is made on your behalf."[50] Indeed, a deceased donor may have lacked requisite capacity prior to death, and certainly a donor lacks capacity upon death or at the point of brain death. However, it should not follow that, upon death, that individual's prior legal consent is rendered voidable.

The statutory provisions that dictate how the public must consent to post-mortem organ donation are misleading because in practice those provisions do not actually produce a binding form of consent. The system of consent that has been established by the current framework is always voidable by death, and since death is a certainty in every case, the consent endorsed by statute is always voidable. As advanced in the foregoing analysis, this is problematic because it seriously infringes on individual autonomy.

In the medical context, and specifically in the context of post-mortem organ donation, autonomy and the public interest should be balanced against one another. Some might argue that there is no

[48] Herring, *supra* note 24 at 207-208.
[49] *Ibid* at 212.
[50] *Ibid*.

need to strike a balance between these two interests (the individual interest and the public interest), because greater autonomy would not necessarily come at the expense of the public interest but might actually further it if greater autonomy led to more donations. But who is to say that greater autonomy would lead to increased donations? In my view, the demand for donation is simply too high not to give similar weight to the public interest factor. But a framework that focuses too heavily on the public interest of increasing donations (and in turn not enough on respecting the autonomous choice to donate or to refuse donation), could obviously then violate autonomy. Therefore, striking a balance between these interests is necessary.

The current provincial framework fails to strike a balance between the public's interest for increased donations and the individual's interest to determine whether to donate. And so, the framework not only fails to give effect to individual autonomy, but also fails to address the societal need for increased organ and tissue donation. In the following discussion, I will address how the framework is violating the public policy that is meant to further post-mortem organ donation.

b) Violation of Public Policy

Public policy can be thought of as a moral value stemming from the "perceived needs of the community."[51] Judicial impression typically determines what is or is not in the public interest[52] and, generally speaking, evidence is not necessary in making findings of public policy.[53] In civil claims, for example, courts will bar certain activities on the basis of public policy if it can be said that the activity at issue is contrary to public or moral interest, or if it is contrary to public conception of justice and morality.[54]

Public policy shares a connection with both legislation and common law. As a general rule, public policy is intended to "reflect a well-informed identification of what will satisfy the public interest articulated by legislation"[55] and in turn "the broad goals identified in legislation and adjudicated in individual cases can be translated into, or applied through, coherent and sensible public policy."[56] In this way, public policy should dictate the objective behind a particular statutory or common law. In other words, the general purpose of legislation and common law should be to satisfy the perceived needs of the public. In the context of organ donation law, the public need should be obvious: more and more people require organ and tissue transplants to live and enhance their lives.

The legislative objective of the *2015 Saskatchewan Act* is to facilitate *inter vivos* and post-mortem donations of human tissues, bodies or body parts.[57] While the legislation acknowledges to some extent (implicitly) the public need for organ donation, it fails to promote the urgent public policy interest of increased donations. This is obviously so considering Saskatchewan's organ donation

[51] Daphne A. Dukelow, ed, *The Dictionary of Canadian Law*, 3rd ed (Toronto: Thomson Carswell Ltd., 2004) at 1035.
[52] *Ibid*.
[53] *Ibid*.
[54] *Simpson v Chiropractors' Assn. (Saskatchewan)*, 2001 SKCA 22, 31 Admin LR (3d) 87, Cameron JA.
[55] Alice Woolley, "Legitimating Public Policy" (2008) 58 UTLJ 153 at 179. Describing the connection between public policy and legislation, Woolley notes at 179: "[i]n general, having democratic legitimacy and instrumental soundness rest on the goodwill, creativity, and budget of particular administrative decision makers is an insufficient protection of democratic values, and of the legitimate instrumental concern that public policy reflect a well-informed identification of what will satisfy the public interest articulated by legislation."
[56] *Ibid* at 154.
[57] *2015 Saskatchewan Act*, *supra* note 6.

statistics, which indicate the objective of the donation legislation is not being achieved. The statistics further indicate a serious and ongoing societal need for increased donations, and as a result, reflect a serious and ongoing violation of public policy.

From a 'societal needs' perspective, overriding a deceased's donative wishes can determine whether a prospective organ recipient lives or dies. As the SHA notes, "one organ donor can save up to eight lives and one tissue donor can enhance the lives of [up to] 75 people."[58] The SHA also notes that approximately 90 people are on the kidney transplant waitlist and they will wait, on average, 2.8 years for a kidney, which is approximately 437 dialysis treatments per person.[59] Clearly, the demand for organ transplants continues to outweigh the supply of available organs, and a framework that relies on substitute decisions to increase post-mortem donation is flawed.

The SHA notes that an individual is more likely to need an organ transplant than they are to become a donor,[60] and the provincial framework has yet to mitigate this problem. According to some American scholars, people fail to communicate their donative intent and families fail to provide the substitute decision to donate, and together these failures are seen as causing organ shortages across the United States.[61] However, more accurately stated, the *state* fails to implement an adequate model that effectively codifies individual donative intent, and in this way, the state remains insensitive to the public need for organ donations.

As we have seen, the current donation framework does not require people to leave donative wishes. Saskatchewan and the rest of Canada (with the recent exception of Nova Scotia) maintain true "opt-in" models for donating post mortem. A key issue with this type of model is that it confuses those people that truly opt out of organ donation with those that "died before they could opt in", and there is a stark difference between those two groups. A donation model that cannot differentiate between people that *do not* consent versus those that *may consent* but died without leaving a record of donative intent will leave many potential opportunities for increased donations untapped. In this way, then, the current opt-in donation model does actually contribute to low donation rates. Indeed, nations that have the opposite, or "opt-out" model for deceased organ donation, report higher rates of post-mortem donations than countries like Canada that have maintained an opt-in framework. However, there are several underlying variables potentially enabling those higher donation rates, and we will examine those in Chapter 4.[62]

The opt-out model is widely referred to as the "presumed consent" system for deceased organ donation. Whether that model discounts our privileges of ownership more or less than the current opt-in framework will also be discussed in Chapter 4.

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[58] "Saskatchewan Health Authority, "Organ and Tissue Donation", online: <https://www.saskhealthauthority.ca/Services-Locations/organ-tissue-donation/Pages/Home.aspx>.

[59] Saskatchewan Health Authority, "Organ and Tissue Donation: Living Kidney Donation", online: <https://www.saskhealthauthority.ca/Services-Locations/organ-tissue-donation/Pages/Living-Kidney-Donation.aspx>.

[60] SHA, "Talk to Your Family", *supra* note 46.

[61] Haley Cotter, "Increasing Consent for Organ Donation: Mandated Choice, Individual Autonomy, and Informed Consent" (2012) 21:2 Health Matrix 599 at 600.

[62] A.M. Rosenblum *et al*., "The authority of next-of-kin in explicit and presumed consent systems for deceased organ donation: an analysis of 54 nations" (2012) 27:6 Nephrol Dial Transplant, 2533 at 2534.

2.2 The Intestacy & Wills Parallel

As we know, across Canada, the law does not intervene to ensure a transfer when people die without leaving instructions concerning their organs and tissue. However, the law does intervene and oversee the transfer of property when people die without a will. Ultimately, intestacy and wills legislation are used to pass on property when people die. In some ways, the organ donation framework is analogous to wills; existing like a special branch of wills in order to facilitate the transfer of organs and tissue.[63] If the donation framework is parallel to a will, then presumed consent is in some ways parallel to intestacy law.

Today**,** when a person dies intestate (without a will), the law ensures that the deceased's property meets the hands of someone else. Pursuant to legislation, the property goes to either the deceased's spouse, next of kin or the Crown. Either way, the property is sure to go to someone, somewhere. Every province and territory in Canada enforces intestacy provisions to this effect.[64] As notable scholar Henry Maine observed, one of the earliest forms of intestacy dates back to ancient times, when jurists viewed the father and son as one unified person, and that unity formed the basis for the "universal succession" concept.[65] One of the underlying reasons for this early form of intestacy was to transfer household power and thus safeguard social stability when death occurred.[66] According to Maine, the law of universal succession meant one man inherited the belongings of another, thus essentially becoming subject to the deceased's rights and liabilities.[67] The successor subsequently held those rights and duties in the same legal capacity as the deceased had held them before dying.[68]

Other forms of succession evolved from this, including inheritance.[69] Inheritance was characteristically similar to universal succession, insofar as the heir still "stepped at once into all the rights and all the duties of the dead man", thereby becoming "instantly clothed with his entire legal person."[70] However, this early form of inheritance differed in that it allowed for co-heirs to benefit under a deceased's estate as opposed to just one beneficiary.[71] Since then, this notion has

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[63] It perhaps goes without saying that it is impractical to "will away" one's organs and tissue given the time-sensitive nature of the transplant process. While it takes time to locate and probate a will, post-mortem organs and tissue have a very short "shelf life" and therefore quick action is required to effectively transfer such property to a new owner. The purpose of the intestacy and wills analogy is to show that governments have established effective ways of transferring a deceased person's property and therefore it is within the realm of possibility to create a process for the effective transfer of organs and tissue.

[64] *Wills and Succession Act*, SA 2010, c W-12.2; *Wills, Estates and Succession Act*, SBC 2009, c 13; *The Intestate Succession Act*, CCSM c I85; *Devolution of Estates Act*, RSNB 1973, c D-9; *Intestate Succession Act*, RSNL 1990, c I-21; *Intestate Succession Act*, RSNWT 1988, c I-10; *Intestate Succession Act*, RSNS 1989, c 236; *Intestate Succession Act*, RSNWT (Nu) 1988, c I-10; *Succession Law Reform Act*, RSO 1990, c S.26; *Probate Act*, RSPEI 1988, c P-21; *The Intestate Succession Act, 1996*, SS 1996, c I-13.1 [*Saskatchewan Succession Act*]; *Estate Administration Act*, RSY 2002, c 77.

[65] Henry Sumner Maine, Ancient Law, 10th ed (New York: Henry Holt and Co., 1906), online: Online Library of Liberty <https://oll.libertyfund.org/titles/maine-ancient-law> at 172.

[66] Paul Milton, "Inheritance as the Key to all Mythologies: George Eliot and Legal Practice" (1995) 28:1 Mosaic, 49 at 52.

[67] Maine, *supra* note 65 at 174.

[68] *Ibid*.

[69] *Ibid* at 175.

[70] *Ibid* at 174.

[71] *Ibid* at 176.

evolved much further and today wills are rarely allowed to dispose of a deceased's assets "with absolute freedom".[72] Public policy limits personal autonomy in the wills context with laws that now ensure a widow or minor child have rights to a definite share of a deceased's estate.[73]

In early Roman law, the transfer of property was actually ancillary to the law's primary objective of transferring household power to the son.[74] While much has changed since the early Roman era, the underlying objectives of today's intestacy and inheritance laws remain similar to what they were back then. The law is still concerned with maintaining social order when a person dies and leaves behind an estate. Thus, the law mandates certain processes for executing a valid will, probating a will, disbursing property under a will, disbursing property when there is no will, and so on, as a means of maintaining social order.

2.2.1 Public Policy and Testamentary Dispositions

Public policy is a consideration when judges make decisions concerning property disbursements under a will. Public policy is invoked in clear cases where public harm is "substantially uncontestable".[75] Courts are required to intervene in the interests of society.[76] Therefore, when a testamentary gift offends public policy, for example, the law will render that gift void, or where appropriate, the law will even go as far as to re-write the testator's gift in a way that balances the testator's intention with public policy in order for the gift to succeed.[77] In other cases, where a condition requires "a beneficiary to act in a manner contrary to law or public policy" in order to receive the gift, "courts will intervene to void the offending testamentary condition on public policy grounds."[78]

Where testamentary gifts are subject to a condition for inheritance and the condition is vague or uncertain, courts prefer to construe a vesting construction if possible so that the testamentary gift vests sooner rather than later.[79] For example, in most jurisdictions testamentary gifts cannot hang in perpetuity[80] and where courts can interpret the language of a gift as a 'condition subsequent',

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[72] *Ibid* at 217.
[73] *Ibid* at 217. See also *The Wills Act, 1996*, SS 1996, c W-14.1; *The Family Property Act*, SS 1997, c F-6.3; *Saskatchewan Succession Act*, *supra* note 64.
[74] Milton, *supra* note 66 at 52. "Household power" refers to an element of the family structure in classical society, when men were formally responsible for the household and the women and children within it. On classical household power, Maine, *supra* note 65 at 119 observed, "[t]he points which lie on the surface of history are these: -The eldest male parent –the eldest ascendant– is absolutely supreme in his household. His dominion extends to life and death, and is as unqualified over his children and their houses as over his slaves…."
[75] *Re Estate of Charles Millar, Deceased*, [1938] SCR 1, 1937 CanLII 10 (SCC) at 2.
[76] *Ibid* at 4.
[77] See for example *Canada Trust Co. v Ontario Human Rights Commission* (1990), 74 OR (2d) 481, 1990 CarswellOnt 486 (WL) [*Canada Trust*].
[78] *Spence v BMO Trust Company*, 2016 ONCA 196 at 56, 2016 CarswellOnt 3345 (WL) [*Spence*].
[79] See *Re Down*, [1968] 68 DLR (2d) 30, [1968] 2 OR 16 [*Re Down*]. Per Laskin JJA (as he then was) at page 36: "There is also the consideration that difficulties of construction such as are posed by the will in this case should be resolved in favour of all the objects of the testator's bounty…." For more on testamentary constructions and the presumption against intestacy, see *H.J. Hayes Co. v Meade* (1987), 82 NBR (2d) 419, 1987 CarswellNB 66 (WL) [*Hayes*].
[80] The rule against perpetuities has been repealed in Saskatchewan, Manitoba and Nova Scotia. For further discussion on reasons for repeal, see for example Law Reform Commission of Nova Scotia, *Final Report - The Rule Against Perpetuities* (Halifax: Law Reform Commission of Nova Scotia, 2010), online: <http://canlii.ca/t/7fd>. For

they will apply that construction over a 'condition precedent' interpretation.[81] A condition precedent is a contingent interest and the testamentary gift will not vest until the beneficiary meets some requirement. On the other hand, a condition subsequent is a vested interest, and the gift passes to the beneficiary and is subject divestment if the beneficiary does not meet a specific requirement.[82] In these ways, it is understood that courts like to see gifts vest and where interpretation is necessary, the court's construction will favour vesting if possible.

How is this relevant to the overall discussion concerning post-mortem organ donation? In common law, there is a general bias toward certainty rather than contingency. In my view, the current organ donation system, although rooted in statute and not common law, provides only for "uncertain dispositions" because the deceased's prior given consent is not actually binding. In this way, a deceased's prior given consent to post-mortem donation is consistent with "uncertain testamentary gifts" that become subject to construction. In the organ donation context, a "vesting" construction would be one that favours post-mortem procurement for the purposes of transferring organs and tissue to another person, and a vesting construction could apply where the deceased gave consent to a post-mortem donation. In presumed consent systems, the vesting construction could apply in cases where the deceased did not opt out of the presumption to donate after death.

Furthermore, when dealing with property in a will, the law is cautious not to offend the testator's intention since, in many ways, the will is perceived as a contract between the deceased and the law. As explained by Godin J in *H.J. Hayes Co. v Meade*, "[t]he cardinal rule of interpretations of wills is that effect must be given to the intentions of the testator."[83] When a person writes a will, they trust in the law to execute his or her final testamentary intentions. Upon death, the will allows that testator to instruct from the grave. Thus, "the court has a responsibility to ensure that only wills that meet the hallmarks of validity are probated."[84] A probated will "represents the testator's true testamentary intentions."[85] The court's responsibility of ensuring validity is a duty owed "to the testators, whose deaths preclude them from protecting their own interests, to those with a legitimate interest in the estate, and to the public at large."[86]

It would be highly offensive to the testator if the law enforced a framework that gave next of kin the ultimate decision-making power over what happens to the deceased's property gifted in a will. In intestacy matters, it would be most bizarre to give the deceased's next of kin the power to determine where that deceased's property ends up. Testamentary law does not put the family's emotions first because the family's emotions and perceptions of 'need' can obscure and oppose the testamentary direction. Disputes over property would be frequent and probably chaotic without the laws that regulate and oversee disposal of property after death. In my view, with this property lens applied, the approach to post-mortem disposal of organs and tissue under the current donation

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conditions void for offending the rule against perpetuities generally, see *Re Tilbury West Public School Board and Hastie*, [1966] 2 OR 20, 55 DLR (2d) 407 (HC) [*Re Tilbury*].

[81] On constructions in favour of vesting, see *McKeen Estate v McKeen Estate* (1993), 132 NBR (2d) 181, [1993] NBJ No 69 (QB); *Hayes*, *supra* note 79.

[82] For further discussion on vested and contingent interests, see Thomas G. Feeney, *The Canadian Law of Wills* (3rd Ed.) (Toronto: Buttersworths, 1987) at 225, 257, 259 and 260; *Re Down*, *supra* note 79; *Hayes*, *supra* note 79.

[83] *Hayes*, *supra* note 79 at para 17 (WL).

[84] *Neuberger v York*, 2016 ONCA 191 at para 118, 129 OR (3d) 721 [*Neuberger*].

[85] *Ibid*.

[86] *Ibid*.

framework appears inconsistent with the sensical principles that have long underpinned property dispositions in these other areas of law.

This brings me to my final point in the intestacy and wills parallel, being the state's inherent concern with property going to waste. The law views 'property being used' as notably better for the economy than property that stagnates for long periods of time.[87] For example, the concern for wasting property (or "the development of otherwise idle property") forms one of the common justifications for the law of adverse possession, which is sometimes referred to as "squatters' rights."[88] The justification behind this kind of law is derived from the principles of economic efficiency and fairness.[89] On economic efficiency, Professor, David Duff, submits:

> Economic efficiency is…a central objective of public policy…. As a normative principle, efficiency favours the allocation of scarce resources to their most highly valued uses in order to maximize aggregate welfare. While the measure of value employed for this purpose might be based on happiness or utility, economic analysis invariably dismisses these standards as indeterminate or unmeasurable, relying instead on more objective measures such as willingness to pay."[90]

In my view, the principles of economic efficiency and fairness underpin the reasoning of Lord Justice Sales of the English and Wales Court of Appeal in *R (on the application of Best) v Chief Land Registrar*.[91] In that case, he observes that "…a primary objective of the law of adverse possession [is that] land should be put to use and not sterilised."[92] Although founded on the tort of trespass[93], adverse possession law serves "valuable social and economic purposes, including that of ensuring that land is kept marketable and is not 'sterilised' by the inaction of the true owner."[94] Inaction can stem from "abandonment or non-use by an owner who has no interest in it or who may have disappeared."[95] Lord Justice Sales further held that "[t]he public interest in having land put to good use and in having clear rules to govern acquisition of title to land which has been abandoned has been taken to override the general concern that a person should not benefit from their unlawful actions."[96] Accordingly, the law of adverse possession places a positive obligation on the true owner of land "to use the land in order to limit the risk that the property might be lost to an adverse claimant."[97] An owner's failure to use their land may result in being statute-barred from suing an adverse possessor of that land.[98] While there is no right to adverse possession in Saskatchewan, other provinces maintain such rights through legislation, and the period of time that

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[87] For more on the economic position that principles of property will lean toward wealth maximization if transferability is pursued, see Bruce Ziff, *Principles of Property Law*, 6th ed (Toronto: Carswell, 2014) at 27-28.
[88] N. Elfant, "Compensation for the Involuntary Transfer of Property Between Private Parties: Application of a Liability Rule to the Law of Adverse Possession" (1984) 79 Northwestern University L Rev 758 at 758.
[89] *Ibid* at 760.
[90] David Duff, "Benefit Taxes and User Fees in Theory and Practice" (2004) 54 UTLJ 391 at 396.
[91] *R (on the application of Best) v Chief Land Registrar*, [2015] 4 All ER 495, [2015] EWCA Civ 17.
[92] *Ibid* at 77.
[93] *Ibid* at 44.
[94] *Ibid* at 107.
[95] *Ibid* at 20.
[96] *Ibid* at 44.
[97] Ziff, *supra* note 87 at 142.
[98] *Ibid* at 140.

an adverse possessor has to possess the land before a true owner is statute-barred from suing can range from ten to twenty years.[99]

The laws of adverse possession, wills, succession, intestacy, abandonment and so on, support the notion that 'use' is one of the key interests in property, so much so that the law has established a number of areas, rules and procedures to ensure use continues by passing property to a subsequent owner deemed in law as having use for it.

Conclusion

The above appraisal shows that laws exist to ensure property will pass to the next rightful owner. The enforcement of intestate succession rules as well as rules of construction that favour gifts vesting and oppose them being contingent for a long time or in perpetuity are clear signals that the law is keen to save property from going to waste by instituting processes that ensure property continues to be productive for as long as it has use. However, notwithstanding these well-established rules, when a person dies without leaving behind instructions concerning organ donation, the law does not intervene the same way it does in intestacy and testamentary circumstances. Worse still, the law upholds an organ donation framework that allows the deceased's next of kin to veto donative intent. In the law of wills, such a format would be abhorrent. A will that is validly executed and probated mandates the disposal of the deceased's property as directed therein.[100] Where there is a lack of clarity in a will, courts will be guided by the testator's expressed intent, or a construction "ascertainable from the language of the will."[101]

With the law of wills in mind, why then does the law uphold such a different framework for the post-mortem donation of organs and tissue? More specifically, why is it that family continues to hold such a powerful place in the organ donation framework? What is it about our organs and tissue that lead the state to refrain from codifying our post-mortem donative wishes? Why are donation frameworks so concerned with the emotional and psychological state of a deceased's family,[102] and why do procurement practices tiptoe around these considerations?[103] If extrinsic evidence is admissible in the law of wills for clarifying testamentary intention,[104] why are signed donation cards and consent registries not enough to confirm intention and initiate post-mortem donations?

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[99] *The Land Titles Act, 2000*, SS 2000, c L-5.1 s 21. In Alberta, the period is ten years. See *Limitations Act*, RSA 2000, c L-12, s 3(1), 3(4). In Prince Edward Island, the period is twenty years. See *Statute of Limitations*, RSPEI 1988, c S-7, s 16.

[100] *Neuberger*, *supra* note 84 at 118; *Spence*, *supra* note 78 at 68.

[101] Per Godin J in *Hayes*, *supra* note 79 at para 17 (WL). On the importance of ascertaining the testator's intention and the admissibility of extrinsic evidence to do so, see the reasons for judgment by Vancise JA in *Ratzlaff Estate v Ratzlaff*, 2002 SKCA 53 at 45-48, 2002 CarswellSask 246 (WL) [*Ratzlaff*] and *Re Tilbury*, *supra* note 80; *Re McKellar*, [1972] 3 OR 16, 27 DLR (3d) 289; *Re Essex County Roman Catholic Separate School Board and Antaua*, 80 DLR (3d) 405, [1977] CarswellOnt 429 (WL). See also Lord Atkin's observation in *Perrin v Morgan*, [1943] AC 399 at page 415, [1943] 1 All ER 187: "I anticipate with satisfaction that henceforth the group of ghosts of dissatisfied testators who…wait on the other bank of the Styk to receive the judicial personages who have misconstrued their wills, may be considerably diminished."

[102] See E.L. Eckenrod, "Psychological/Emotional Trauma of Donor Families" (2008) 40 Transplantation Proceedings 1061-1063.

[103] See Margareta A. Sanner, "Two perspectives on organ donation: experiences of potential donor families and intensive care physicians of the same event" (2007) 22 Journal of Critical Care 296 at 303.

[104] *Ratzlaff*, *supra* note 101; *Canada Trust*, *supra* note 77.

If we think of organs and tissue as our property, we ought to be able to decide where these things go when we die. Where we have failed to make any instruction during our lifetime, the government ought to have a process in place that mitigates against the waste of such property. But where we are unable to make these decisions (as minors or adult dependants) or where we wish to defer the decision to someone else, the government should also have a process that qualifies the next of kin's role in such situations.

In the *inter vivos* context, competent adults can make informed decisions to gift their organs, tissue and blood. Generally speaking, where it is clinically viable, especially in life saving circumstances, these "gifts of life" will transfer pursuant to the intent of the living donor.[105] The law recognizes and respects autonomous choice in *inter vivos* organ donations, as it does in testamentary contexts. So, what changes in the post-mortem donation context that causes the law to downplay donor and non-donor instructions? Why does the law differentiate its concern for wasting realty from the concern for wasting organs and tissue? Chapter 3, which follows, will investigate why organs and tissue are treated differently after we die and will question whether, according to property theory, we should have personal ownership in our organs and tissue.

[105] *Inter vivos* transfer of organs and tissue is legislated in all provincial and territorial donation statute. For the Saskatchewan provisions concerning "Gifts for Transplants During Life", see the *2015 Saskatchewan Act*, *supra* note 6 at ss 5, 6.

CHAPTER 3
Defining Property

When we think of property, we tend to think of land and other tangible objects; or, generally, things we can see and touch. My house is property; the park is property; that cellphone is property. In this way, when we think of property in the everyday sense, we also – but perhaps unknowingly – tend to think of those things in relation to ownership or function. By exploring theoretical bases of property and law, this chapter aims to show that there are principled reasons for treating body parts as personal property in the organ donation context.

First, through a review of A.M. Honoré's incidents of ownership, this chapter will demonstrate how property is more than a thing; that it is a legal construct that develops when a right of ownership to a particular thing is legally enforced by law. Through this rights-based appreciation of "property", Part 1 of this chapter surveys areas of our current legal system that show signs that Honoré's characteristics of personal property ownership have already been recognized and enforced in body parts in certain contexts. In doing so, this section will demonstrate a clear and necessary connection between property and law.

Part 2 of this chapter focuses on the intersection between property and law. Since property is a legal construct, an understanding of property's formation would be incomplete without further consideration for what qualifies rules as "law", or in this context, what qualifies ownership as an enforceable right to property. Accordingly, Part 2 of this chapter will turn to theoretical explanations for how the law comes to be. In reviewing law according to both natural law and legal positivist theory, this section will demonstrate how two seemingly contrasting theoretical explanations of law can substantiate arguments in favour of enforceable personal property rights in body parts within the organ donation context.

3.1 What is Property?

What is property? What constitutes property? How do we know when something is property? These questions have been the subject of much academic debate for many years and they continue to divide opinion. To the average person, property is understood as a word that denotes ownership. In this sense, the use of the word "property" is typically applied as a label to show ownership over objects or things.[1] Most people will have heard or used phrases such as "Get off my property!" or "Hey! That's mine!" but not all people realize the legal nuances of those phrases. Still, in the general sense, the concept of property and the word, "property", do convey a right to some object or thing. This general concept of property traces to the law's deeper consideration and regulation of ownership. As Jeremy Waldron puts it, "[t]he concept of property is the concept of a system of rules governing access to and control of material resources."[2]

[1] C.B. Macpherson, "The Meaning of Property" in C.B. Macpherson, ed, *Property: Mainstream and Critical Positions* (Toronto: University of Toronto Press, 1978) 1 at 2.

[2] Jeremy Waldron, *The Right to Private Property* (New York: Oxford University Press, 1988) at 31. For incorporeal property ("intellectual property, property in ideas and inventions, reputations, stocks and shares, choses in action, even positions of employment") see Waldron's discussion, *ibid* at 33-37.

In law, the term "property" describes the relationship and legal rights that people have to things. Much like its use in the general sense, "property" serves as a symbol of legal ownership. But ownership is more deeply understood in law as invariably forming the basis for all property. Thus, when we speak of property in law, we really speak of ownership and "…those legal rights, duties and other incidents…" dispensed by our legal system to connect a person (or persons) to a particular thing.[3] In this way, property has been considered not just as material objects but also as a bundle of rights[4] or "a collection of rights (over things) enforceable against others."[5]

Jeremy Waldron describes tangible property as a material resource and explains that "[s]omething is to be regarded as a material resource if it is a material object capable of satisfying some human need or want."[6] According to the legal philosopher, A. M. Honoré, unfettered ownership of a property (i.e. of a material resource) is the greatest interest that can be held in law, and it involves the right to use, exclude, lend, sell or will a material resource away.[7] Still, ownership has its limits and to use Honoré's example, an owner is not free to use her personal property in a way that would cause physical harm against her neighbor. The law will always regulate the scope of ownership of (i.e. the rights to) a particular property.

With regard to the law's regulation of ownership, Honoré submits that common features of ownership will transcend particular legal systems.[8] These he termed "the standard incidents of ownership", and they include (1) the right to possess; (2) the right to use; (3) the right to manage; (4) the right to the income; (5) the right to the capital; (6) the right to security (i.e. the right to remain owner indefinitely); (7) the incident of transmissibility (i.e. the ability to transfer to a successor); (8) the incident of absence of term[9] (i.e. the ability to enjoy the thing in absence of term); (9) the prohibition of harmful use; (10) liability to execution (i.e. *executability*; that the owner's interest can be taken away to pay for a debt; and (11) the incident of residuary character (i.e. when interests lesser than ownership terminate, such as leases or easements, the law provides for corresponding rights to vest back into the owner).[10]

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[3] A. M. Honoré, "Ownership" in Oxford Essays in Jurisprudence (First Series), A.G. Guest, ed., (Clarendon Press: Oxford, 1961) 107 at 107.
[4] *Ibid*.
[5] Bruce Ziff, *Principles of Property Law*, 6th ed (Toronto: Carswell, 2014) at 2, referring to C.B. MacPherson's take on property as depicted in Macpherson, *supra* note 1.
[6] Waldron, *supra* note 2 at 31.
[7] Honoré, *supra* note 3 at 108.
[8] *Ibid*.
[9] As explained by Imogen Goold, Professor of Law at University of Oxford, "…absence of term is related to transmissibility as both affect the duration of ownership. Absence of term refers to the indeterminate length of one's ownership rights…Ownership, thus, would continue indefinitely unless terminated by the owner, but for the fact that at some point the owner will die. It is for this reason that an indeterminate interest must be linked to a power of transmissibility to deal with the fate of the object upon the owner's death. An interest for life differs slightly, as it is determinate, ceasing at death." Goold notes that in relation to human tissue "there may be problems with determining who is the owner with an indefinite interest" because common law cases and human tissue legislation are silent on absence of term in relation to human tissue. Statute provides a consent format and defines uses for tissue, but the legislation does not "contain any suggestions that once it has been used the right to use it ceases, or that possessory rights cease either. In the absence of such provision, it seems that most [but not all] researchers, hospitals and tissue banks have simply continued to hold tissue indefinitely." See Imogen Goold, "Sounds Suspiciously like Property Treatment: Does Human Tissue Fit within the Common Law Concept of Property?" (2005) University of Technology Sydney Law Review 62 at 64-65.
[10] Honoré, *supra* note 3 at 107.

In describing his eleven "standard incidents of ownership", Honoré notes that full ownership can be recognized where there is most, but not necessarily all, of his incidents accounted for.[11] In this way, Honoré's approach to identifying property is broad and flexible and recognizes that not all things that people generally consider to be "property" will share all of the same characteristics of ownership.[12] Thus, even though not all eleven incidents will apply to things we know as property, there will inevitably be a nexus between all things that are considered to be property because those things will comprise certain characteristics of ownership.[13] In this way, Honoré's theory compliments our consideration of personal property ownership in organs and tissue because it is such an open and flexible theory.[14]

Even though Honoré himself observed that "a person is not, in most systems, regarded as owning his body...", he qualified this statement to the era in which it was said, observing further that personal ownership in one's body is influenced by the fact that body parts were, at that time, not considered external material objects.[15] And this was true. Honoré penned his theory of ownership in 1960 when transplant surgery was still in its infancy "and a multitude of medical technologies and applications utilizing the body and its parts and products were decades away".[16] Accordingly, we need not visit each of Honoré's incidents in great detail, but the following discussion provides a brief focus on a select few to enhance arguments in favour of personal property ownership in organs and tissue.

3.1.1 Incidents of Ownership in the Human Body

a) The Right to Possess & The Ability to Transfer

Honoré's first incident of ownership is "the right to possess", being the right to "have exclusive physical control of a thing, or to have such control as the nature of the thing admits".[17] Interestingly, Honoré reduced this incident further, and clarified that it can be "divided into two aspects, [1] the right to be put in exclusive control of a thing and [2] the right to remain in control," the latter of which is underscored by the notion that others should not interfere in that control without permission.[18] Honoré also argued that a legal system protects ownership where it has established "rules and procedures for attaining these ends".[19] Jeremy Waldron would add that property rules help determine "peacefully and reasonably predictably who is to have access to which resources for what purposes and when."[20]

This incident of possession already fits with our notions of possession of the body and body parts of the living, the dead, and the dying. Theories of informed consent, physician fiduciary duty, and civil law measures like the current consent framework for *inter vivos* organ donation all point to a legal system with established rules and procedures for putting individuals in exclusive control over

[11] *Ibid* at 112-113.
[12] Muireann Quigley, "Property and the body: Applying Honoré" (2007) 33 J Med Ethics 631 at 632.
[13] *Ibid*.
[14] *Ibid*.
[15] Honoré, *supra* note 3 at 130.
[16] Quigley, *supra* note 12 at 632.
[17] Honoré, *supra* note 3 at 113.
[18] *Ibid*.
[19] *Ibid*.
[20] Waldron, *supra* note 2 at 32.

their body parts. Even the post-mortem donation provisions aim (albeit not well) to give people exclusive and binding authority to decide whether their own organs and tissue will be donated after death. Donation legislation outlines the procedures for these autonomous choices to be recorded, but these procedures are then skewed by infringing procurement practices (namely, the practice of validating the deceased's prior given consent with the family's subsequent consent) and health region donor cards that should serve as a mechanism for recording legal consent as outlined in the statute, but do not.

The donation frameworks also demonstrate Honoré's incident of transmissibility. By way of human tissue legislation, the law has put in place rules and procedures for the *inter vivos* and post-mortem transfer of our organs and tissue to a successor. This is akin to the law's recognition of cars as property, and to the rules enacted for transferring ownership in a car to a buyer, to a relative or to the owner's estate.

b) The Right to Security

Like the "right to possess", the "right to security" as a standard incident of personal property ownership (i.e. the right to remain the owner of an object indefinitely) is inherent in the very nature of organs and tissue. People want to remain the owner of their body parts for as long as they so choose and organ donation law recognizes this, particularly in the *inter vivos* donation context. Even though most people are born with two functioning kidneys and only need one to live, the law does not force people to give up a kidney to save the life of someone who could die because they do not receive a transplant. Indeed, the 'right not to have a kidney taken from one's body against his or her will' is not only about property ownership but is also protected by *Charter* guarantees of life, liberty and security of the person.[21] The effect of those rights is consistent with recognizing ownership of our organs and tissue because they provide for the right to remain the indefinite owner of our body parts. In this way, the law *can* and inadvertently *does* recognize this incident of ownership in our body.

c) The Right to Use & The Right to Manage

In line with the property incidents of possession and security, our legal system has also established rules around how an individual uses, manages and secures their personal body and this, too, is consistent with recognizing ownership of our organs and tissue. The rights to life, liberty and security of the person as guaranteed under the *Charter* come to mind again when thinking about how the law has established rules and procedures for using, managing, and securing our body parts. And while the *Charter* does not guarantee or constitutionalize any property right, it does constitutionalize the protection of the person – by guaranteeing that state laws will not infringe on our life, on our liberty and on the security of our person.[22] This guarantee is exemplified by the decriminalization of abortion[23] and physician assisted suicide,[24] as well as the striking down of certain *Criminal Code* provisions found to violate sex workers' rights to security of the person.[25] In my view, prohibitions on certain actions with a body are consistent with "general constraints on action" that are often applied to property. As Jeremy Waldron puts it, prohibitions on harmful

[21] *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11, s 7.
[22] *Ibid*.
[23] *R v Morgentaler*, [1988] 1 SCR 30, [1988] SCJ No 1 (WL).
[24] *Carter v Canada (Attorney General)*, 2015 SCC 5, [2015] 1 SCR 331.
[25] *Canada (Attorney General) v Bedford*, 2013 SCC 72, [2013] 3 SCR 1101.

behaviour are really just "a general constraint on action."[26] When society sets limits on what may be done with a particular resource, "we can locate rules about property within those limits" and determine "which (generally permissible) actions may be performed with which resources."[27]

In this way, striking down prohibitions against particular actions with a body (abortion and physician assisted suicide) not only lifts certain constraints, but also signals that the *Charter* protects our abilities to control the integrity of our body, and by extension the *Charter* defends the individual's dominion over his or her own body and parts thereof by guaranteeing that the state will not employ laws that interfere with the individual's control over them. In my view, the lifting of these constraints is an indicium of personal property ownership in our body and body parts. This idea harks back to the "control" element of possession, which we discussed is based on the notion of non-interference by others without the owner's permission.

d) The Right to Income

Moreover, "a right to the income" as a standard incident of personal property ownership is also exemplified where people are lawfully enabled to earn income from their own body. For example, Canadians can be compensated for participating in clinical research trials and the scope of compensation is regulated by Health Canada.[28] Health Canada employs the Good Clinical Practice standard (GCP) when overseeing and regulating trials requiring human participation.[29] Approximately 900 clinical trials are authorized each year by Health Canada,[30] and trial financing is provided by sponsors like pharmaceutical or biotech companies, as well as disease foundations and charities.[31] Health Canada's GCP guidelines recommend that the participant's informed consent form contain information outlining, among other things, the "anticipated prorated payment, if any,…for participating in the trial."[32]

In 2018, a Tri-Council Policy Statement[33] was established by Canada's three federal research agencies – the Canadian Institutes of Health Research (CIHR), the Natural Sciences and Engineering Research Council of Canada (NSERC), and the Social Sciences and Humanities Research Council (SSHRC) – which aims "…to promote the ethical conduct of research involving humans."[34] Regarding payment for human participation in clinical trials, the policy states that incentives can be "monetary or otherwise" and "differ from reimbursements and compensation for injury…."[35] The policy further notes that "[w]here incentives are offered to participants, they

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[26] Waldron, *supra* note 2 at 32.
[27] *Ibid*.
[28] Government of Canada, "Health Canada's Clinical Trials Database" (07 June 2016), online <https://www.canada.ca/en/health-canada/services/drugs-health-products/drug-products/health-canada-clinical-trials-database.html> [Clinical Trials Database].
[29] Health Canada, *Good Clinical Practice: Integrated Addendum to E6(R1)* (Health Canada Guidance Document) (25 May 2017), online <https://www.hc-sc.gc.ca/dhp-mps/alt_formats/pdf/prodpharma/applic-demande/guide-ld/ich/efficac/e6r2-step4-eng.pdf> at 1 [Health Canada Clinical Trial Guidance Document].
[30] Clinical Trials Database, *supra* note 28.
[31] It Starts With Me, "Glossary: Sponsor", online <https://itstartswithme.ca/faq/#clinical-research>.
[32] Health Canada Clinical Trial Guidance Document, *supra* note 29 at 20.
[33] Canadian Institute of Health Research *et al., Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* (December 2019), online <https://ethics.gc.ca/eng/documents/tcps2-2018-en-interactive-final.pdf>.
[34] *Ibid* at 3.
[35] *Ibid* at 29.

should not be so large or attractive as to encourage reckless disregard or risks" which "…may amount to undue inducement and thus negate the voluntariness of participants' consent."[36] Despite the caution surrounding participation incentives, the transactional relationship between a healthy participant and the sponsoring organization is consistent with the notion of 'sale' and exemplifies legal recognition of personal property ownership in one's own body.

Interestingly, legal prohibitions on compensation for certain parts of the body are actually not as exhaustive as we might think they are. For example, in Saskatchewan and New Brunswick, paid plasma donation is possible at private plasma clinics. In Saskatchewan, the enabling law is found at s 17 of *The Human Tissue Gift Act*[37] and for New Brunswick it is s 10(1) of the *Human Tissue Gift Act.*[38] Other Canadian provinces have yet to establish clinics but have similar statutory provisions that enable compensation for plasma donation as well as other regenerative material in some jurisdictions.[39]

In Saskatoon and Moncton,[40] Canadian Plasma Resources (CPR) will pay qualified donors for their blood plasma "wherever provincial law allows."[41] CPR's website states that it will compensate qualified plasma donors up to $60 per donation, and that donors can give plasma twice in a seven day period.[42] CPR claims the compensation is a show of appreciation for "the time, commitment and, in some cases, the expense that…donors dedicate to helping others."[43] CPR also acknowledges that its paid plasma donation program "…ensures a secure and safe supply of plasma for patients that need it."[44] On its website, CPR also incentivizes donations with a donor loyalty program, through which donors are entered to win "valuable gifts and prizes each year."[45]

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[36] *Ibid* at 29.
[37] *The Human Tissue Gift Act*, SS 2015 c H-15.1 [*2015 Saskatchewan Act*].
[38] *Human Tissue Gift Act*, RSNB 2014, c 113 [*New Brunswick Act*].
[39] For other provinces that enable paid plasma donation, see the *Human Tissue Gift Act*, RSBC 1996, c 211, s 10; *The Human Tissue Gift Act*, SM 1987-88, c 39, CCSM c H180, s 15(1); *Trillium Gift of Life Network Act*, RSO 1990 c H.20, s 10(2); *Human Tissue Act*, RSNL 1990, c H-15, s 18; *Human Tissue Gift Act*, RSY 2002, c 117, s 10; and *Human Tissue Gift Act*, RSNS 1989, c 215, s 11 (repealed; repeal in force January 18, 2021). Compensation remains possible under Nova Scotia's new legislation, the *Human Organ and Tissue Donation Act*, SNS 2019, c 6 (in force January 18, 2021), which prohibits dealing in organs, tissues or bodies for valuable consideration (s 27(1)) but the Act does not apply to blood, blood constituents and certain regenerative material (s 3). Section 27(2)(c) also carves out power for the health authority or Minister to authorize the buying and selling of tissues by the tissue bank. Prince Edward Island, the Northwest Territories and Alberta also make compensation possible. The *Human Tissue Donation Act*, RSPEI 1988, c H-12.1 prohibits the commercial transaction of tissue (s 15) but blood, blood constituents and certain regenerative material are among parts excluded from the definition of tissue (s 1(g)). The *Human Tissue Donation Act*, SNWT 2014, c 30 similarly prohibits the commercial transaction of tissue (s 18) but excludes blood, blood constituents and certain regenerative material from the definition of tissue (s 1). Similarly, the *Human Tissue and Organ Donation Act*, SA 2006, c H-14.5 prohibits "reward or benefit" for the transplantation of any body part (s 3(2)) but the Act does not apply to blood, blood constituents, certain regenerative material and by-products used for a purpose other than transplantation (s 2).
[40] CPR clinics are located in Saskatoon, Saskatchewan and Moncton, New Brunswick. See Canadian Plasma Resources, "Contact", online <https://giveplasma.ca/contact/>.
[41] Canadian Plasma Resources, "Compensation", online <https://giveplasma.ca/become-a-donor/compensation/> [Canadian Plasma Resource, "Compensation"].
[42] *Ibid*.
[43] *Ibid*.
[44] Canadian Plasma Resources "Blood Donation VS Plasma Donation: An In-Depth Look" (23 January 2020), online <https://giveplasma.ca/blood-donation-vs-plasma-donation-an-in-depth-look/>.
[45] Canadian Plasma Resource, "Compensation", *supra* note 41.

Some may argue that CPR's compensation is for the service of donating rather than for the sale of plasma, but in my view the argument is one of semantics. Although the language surrounding CPR's payment and incentive program excludes terms like "buy" and "sell", the transaction between CPR and the plasma "donor" is ultimately an exchange of a good (being plasma) and a service (donating) in exchange for money.[46]

The argument that compensation is for the service of donating also seems inconsistent with the enabling law that allows blood plasma to be collected for compensation. For example, Saskatchewan and New Brunswick employ the language of "sale" in their statutory provisions. The substance of both provisions is that "…no person shall buy, sell or otherwise deal in, directly or indirectly, for a valuable consideration, any tissue for a transplant, or any body or part of a body *other than blood or a blood constituent*, for the purposes of transplant, medical education or scientific research".[47] In my view, the language suggests that the payment is more so for the blood constituent (being the plasma) than it is for the service of donating. However, putting this debate aside altogether, the fact that the law allows for this transaction in the first place (regardless of what we wish to attribute the compensation to) is still consistent with the notion of 'sale' and serves as another example of the legal recognition of personal property ownership in one's own body.

In Canada, the law's prohibition on the sale of other parts of the body, such as kidneys, liver, heart, lungs, and so on, does not necessarily preclude arguments for personal property ownership in these and other organs and tissue. To relate the "income" indicia of ownership to an ownership context that we are familiar with, take for example the patient who buys prescription drugs which they then own but are prohibited from selling to other people. It was legal for the drug manufacturer/pharmacy to profit from the sale of that medicine to the patient, but the patient is prohibited from selling that prescription medication to someone else. In such a scenario, the 'income indicia' is present up until ownership of the medication transfers to the patient, but the medication is still considered to be a property and is made no less a property by the subsequent restraint on alienation.

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[46] Blood donors are not yet compensated even though the physical act of donating blood is quite similar to donating plasma, albeit donating blood is less time-consuming than donating plasma. According to the World Health Organization (WHO), voluntary non-remunerated blood donations contribute to a safe blood supply for patients requiring transfusions. See World Health Organization, *Report on Global Consultation: 100% Voluntary Non-Remunerated Donation of Blood and Blood Components* (World Health Organization, Geneva, 2009). While blood plasma can be cleaned of diseases, blood itself cannot, and on this line of reasoning, the WHO intimates that a money incentive to increase blood donations would negatively impact the quality of the blood supply, as people with blood diseases would be more apt to come forward and donate under false declaration of clean blood. However, blood donation is rigorously screened for disease and so the science substantiating the WHO's policy on non-commercialization of blood donation remains unclear. Arguably, the WHO's policy is only substantiated by evidence from uncontrolled studies that used non-random samples. See, for example, T. Eastlund, "Monetary blood donation incentives and the risk of transfusion-transmitted infection" (1998) 38:9 Transfusion 874-882. For the argument that randomized field trials (which are typically relied on to form health policy) show that donor pools are not worsened by money incentives, see Nicola Lacetera and Mario Macis *et al.*, "Economic Rewards to Motivate Blood Donations" (2019) 340: 6135 Science 927-928. In that study, the authors suggest that the evidence rendered under those uncontrolled studies of non-random samples has unfortunately driven laws and policies that ban economic incentives for blood, organ and reproductive tissue donation in many countries.

[47] *2015 Saskatchewan Act*, *supra* note 37 at s 17. For the near-identical law in New Brunswick see *New Brunswick Act*, *supra* note 38 at s 10(1): "No person shall buy, sell or otherwise deal in, directly or indirectly, for a valuable consideration, any human tissue for a transplant or any human body or part of any human body, other than blood or a blood constituent, for therapeutic purposes or for the purposes of medical education or scientific research."

As Professor Muireann Quigley has observed, it is acceptable to the bundle of rights theory that "the body might be considered property on some occasions or in some situations but not others. For that reason, it simply does not matter if it is concluded that, for example, the right to income of the thing when applied to the body does not include of the sale of body parts."[48] Even though the sale of certain body parts is prohibited, ownership in organs and tissue is nonetheless still evidenced by those occasions where a person can exchange a bodily substance, like blood plasma, for compensation.

3.1.2 Limitations & Enforceability of Ownership

Limitations on the scope of ownership (e.g. that a thing can be *inter vivos* donated but cannot be sold) does not preclude the thing from being property. On the contrary, constraints on ownership are expected and part of the normative framework governing personal property ownership. Some medicines can be sold for money and some are illegal to sell, but both medicines are still known to be the personal property of someone. Although the law prohibits the sale of a liver but allows compensation for blood plasma donation, it does not automatically follow that the liver is any less property than blood plasma. Quite the reverse, the law's control of the sale of body parts suggests that both the liver and blood plasma are property requiring limitations as to how they can be alienated from one owner to another, much like other property ownership that is regulated by the law (like prescription medications, vehicles, guns, etc.). Again, limitations on the scope of ownership do not preclude the thing from being property.

Still, notwithstanding that human body parts seem to check several of Honoré's incidents of ownership, the law has long established that a person does not own their body. Rather, the person is considered to have "a right to bodily security or liberty,"[49] but this right has not extended into the realm of property rights in one's own body. While this might seem inconsequential, the difference between a right to bodily security or liberty versus a personal property right in our bodies is that, when we die, our organs and tissue are not treated as objects of personal property. This is problematic because once we die our prior choices about our body seem to fall into the crack where property law fails to extend to our post-mortem body. When this happens, and it inevitably *does* happen every time someone dies under the current donation framework, our choices about where we want our body parts to go are not safeguarded by the same protections afforded to choices concerning property.

As we have come to know, property is largely understood to be an enforceable right to a particular thing.[50] Therefore, to have a legally recognized claim (i.e., to have 'ownership') in some thing, it is imperative that the law enforces that claim. With law's enforcement, the right to the thing is legally recognized and the same is true in reverse: i.e., without law's enforcement, the right to the thing is not legally recognized.[51] Without law's recognition, that claim is unsubstantiated and 'is not good against the world'. Put another way, that claim will not trump claims to the same object that may be made by others. Thus, the enforceability factor of the asserted ownership right is absolutely imperative. In this way, then, objects that may be property are only truly property if they

[48] Quigley, *supra* note 12 at 632.
[49] Honoré, *supra* note 3 at 129.
[50] Macpherson, *supra* note 1 at 11.
[51] *Ibid*.

can be owned. And an object can only truly be owned if the law not only recognizes that ownership but enforces or gives effect to that ownership as well.

Depending on whom you ask, the law's enforceability of an ownership right is contingent on different things. What I aim to show in the discussion that follows is that two ostensibly contrasting theoretical views of jurisprudence can support the case for personal property ownership in organs and tissue. First, I will explore the natural law theory of jurisprudence, which is of the view that the law's enforceability of a right will depend on whether society believes that the right to ownership over an object is moral. If it is moral, i.e., if society believes that there 'ought to be' personal property ownership in the object, then law will enforce that ownership claim.

In contrast, I will also explore the legal positivist theory of law as according to H.L.A. Hart. Per Hart's approach to legal positivism, the enforceability of an ownership right will depend on whether human body parts fall within the 'penumbra' of property law, and then, if they do, whether the established rules of property should, based on social aim and policy, apply to this penumbra problem.

3.2 Property in Theories of Jurisprudence

a) Natural Law Theory

Generally speaking, natural law theory believes that there is a necessary connection between law and morality. The traditional view of natural law theory stresses that "it is essential to the concept of a legal system that the apparatus of rules, courts and government, is aimed at the common good."[52] From the natural law perspective, "when there is a conflict between natural law and human law, natural law must take precedence" and therefore "all human-made law must be in accordance with the fundamental natural law principles", such as "notions of doing good, avoiding evil and promoting the common good."[53] For a rule to be legitimately called a "law", it must be morally justified, according to natural law theory.[54]

In this same vein, natural law theory believes that property rights "have legitimacy independently of, and antecedent to, government."[55] In the early days of natural rights theory, John Locke famously defended individual rights against government authoritarianism in *Two Treatises of Government* (1689). In that work he explained,

> Though the Earth, and all inferior Creatures be common to all Men, yet every Man has a Property in his own Person. This no Body has any Right to but himself. The Labour of his Body, and the Work of his Hands, we may say, are properly his. Whatsoever then he removes out of the State that Nature hath provided, and left it in, he hath mixed his Labour with, and [joined] to it something that is his own, and thereby makes it his Property. It being by him removed from the common state Nature placed it in, it hath by this labour something annexed to it, that excludes the

[52] N.E. Simmonds, *Central Issues in Jurisprudence: Justice, Law and Rights*, 2nd ed (London: Sweet & Maxwell, 2002) at 158.
[53] William C. Starr, "Law and Morality in H.L.A. Hart's Legal Philosophy" (1984) 67:4 Marquette Law Review 673 at 673-4.
[54] *Ibid* at 674.
[55] B. Bjorkman & S. O. Hansson, "Bodily Rights and Property Rights" (2006) 32:4 J Med Ethics 209 at 209.

> common right of other Men. For this Labour being the unquestionable Property of the Labourer, no Man but he can have a right to what that is once [joined] to, at least where there is enough, and as good left in common for others.[56]

Interestingly, the starting point of Locke's theory of private ownership is first and foremost the assumption that we have property in ourselves, or "in his own Person" as he puts it. According to Locke, people have a duty to preserve themselves and God's other creatures, and rights to land and other things are integral in order to carry out such a duty.[57] When carrying out this duty of preservation, we mix our labour with objects, thereby adding value to those objects and thereby making us the legitimate and exclusive owners of that object.[58]

However, some theorists have pointed out that mixing labour with an object does not necessarily add value to it, nor does it necessarily provide a basis for legitimate ownership over the entire object since arguably the labourer should only be entitled to the added value, if there is any.[59] In this way, and in the context of identifying the contents of property rights, the natural rights theory of property has been called an "all or nothing theory."[60]

Notwithstanding its supposedly limited application, the Lockean view of mixing labour with objects has served as the basis for some courts ruling that hospitals hold property in excised organs and tissue, or in cell lines created from excised bodily specimens, because of added labour from altering or storing removed body parts.[61] Yet, in matters concerning human cadavers, the notion that relatives have property in a deceased's body has not found favour by the courts, and some argue that this is largely based on the Lockean view that the relatives' labour has not been mixed with the corpse and therefore the body is *res nullis* (owned by no one).[62] In this way, the Lockean view seems consistent with relatives *not* having property in a deceased's body.

On the contrary, some might argue that Locke would support a decision-making role for next of kin grounded in a property right based on their "labour of love". Supporters of this view could argue the next of kin's labour has "mixed" with the deceased individual over time, thus establishing a temporary or, in instances of death, permanent, right to control the fate of the individual's objects, which include organs, tissue, or the body as a whole. The substitute decision-making provisions within organ donation legislation may be consistent with this view insofar as they authorize the people closest to us to determine what will be done with our organs and tissue. Where the individual lacks the requisite capacity to make donative decisions, or in those instances where donative intent is "double checked", the law assumes that the people closest to us are the most appropriate

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[56] John Locke, "Chapter 5: Of Property (from *Second Treatise of Government*)" in C.B. Macpherson, ed, *Property: Mainstream and Critical Positions* (Toronto: University of Toronto Press, 1978) 15 at 18.
[57] Bjorkman & Hansson, *supra* note 55 at 209.
[58] *Ibid*.
[59] *Ibid*.
[60] *Ibid* at 210.
[61] *Ibid*. For examples, see *Moore v Regents of the University of California*, 51 Cal (3d) 120 (1990), 793 P2d 479; *Piljak Estate v Abraham*, 2014 ONSC 2893, [2014] OJ No 2665 (QL).
[62] Bjorkman & Hansson, *supra* note 55 at 210. There are undoubtedly other concerns that contribute to the notion that relatives do not have property in a deceased's body, such as concerns for public health, disease control or mishandling of corpses.

substitute decision-makers. In this way, the law empowers family members with ownership rights over the body, and thus there may be some consistency with the Lockean view.

However, the Lockean view encounters a flaw if used as a theoretical explanation in support of relatives having property in a deceased's body. When the law empowers family members with ownership rights over the body, it denies those same ownership rights to the person whose body it was. The Lockean view of property favours the primary labourer, and who puts more labour into our own organs than ourselves? The body and its collection of parts are in some sense one and the same and it should follow that the person whose body it was should be able make binding decisions concerning where his or her body and body parts go upon death.

Adding to this thought experiment, I further submit that post-mortem organ and tissue donation is very much in line with the Lockean view of property. Reflecting once again on Honoré's incidents of ownership, we recall that organs and tissue seem to be as much property as any other tangible object that comes to mind when we think of things we own. If we consider that death is imminent and is one of the most natural states of life, we should appreciate how modern medicine has established a window of opportunity within which Locke's 'State of Nature' (being death) 'hath provided' organs and tissue into a common domain from which those properties "ought to be" removed from the body to become the property of another living person (the organ recipient) who will inevitably mix their labour into the property. Accordingly, Locke's age-old theory of private property ownership can validate meaningful reform on moral grounds.

b) Legal Positivist Theory

Sitting opposite to the natural law theory of jurisprudence is legal positivism. Like the natural law approach, legal positivist theory also views property as a legal construct. However, the traditional view of legal positivism believes that natural law theory unnecessarily confuses law and morality.[63] According to the traditional and more formal view of legal positivism, law and the legal system "should be explicated in terms of purely factual, non-moral criteria".[64]

On this account, the common thesis of legal positivist theory is that there is no necessary connection between law and morality. Subscribers to this notion maintain that "a legal system is a closed logical system in which correct decisions can be deduced from predetermined legal rules by logical reasons alone."[65] From this perspective, the legal positivist would argue that the enforceability of an ownership claim depends on whether the subject making the claim and the object being claimed actually fall within the "juridical definition of property."[66] In this way, legal positivists believe that the formal principles of justice, being predetermined legal rules, are desirable to our legal system.[67] It is a "basic principle of fairness" that the legal system "should treat like cases alike, and different cases differently", according to legal positivism.[68]

[63] Simmonds, *supra* note 52 at 159.
[64] *Ibid*.
[65] Starr, *supra* note 53 at 681.
[66] Ziff, *supra* note 5 at 2.
[67] Starr, *supra* note 53 at 681.
[68] *Ibid*.

From the perspective of a legal positivist, property has been understood in relation to rights and the term property refers to the entitlements that the law has recognized in relation to ownership.[69] As so eloquently put by Jeremy Bentham, "[p]roperty and law are born and die together. Before laws were made there was no property; take away laws and property ceases."[70] In this way, the positivist approach views property as a construction of law, and the juridical definition of property will determine the objects of property and the subjects that can own it.[71]

According to legal positivist H.L.A. Hart, a law will govern a certain type of behaviour, but there must be a common understanding (or "settled meaning") in society of what the particular behaviour is that the law governs.[72] And in addition to this "settled meaning" which is at the core of the law, there is also Hart's so-called "penumbra", which rests on the periphery of that core and wherein fall those "debatable cases" dealing with behaviours/words that are "neither obviously applicable nor obviously ruled out" by the governing law.[73] Put another way, someone must decide whether the legal rule can extend to govern the penumbra issues that do not necessarily fall within the settled meaning of the behaviour that the law is established to govern.[74] Determining whether a penumbra problem falls within the scope of a legal rule cannot be established by logical deductive reasoning, according to Hart.[75] Rather, the determination of penumbra problems must be "sound or rational without being logically conclusive".[76]

According the Hart, the criterion that makes penumbra decisions sound is the concept of "what the law ought to be" – and this criterion demonstrates the necessary intersection between law and morality. Thus, Hart's legal positivist theory is not as rigid as the common thesis of legal positivism, which seems to be emphatic about the judicial process being "primarily a deductive reasoning process."[77] As Hart observes, any insistence on the separation of law and morals is misleading and false because it fails to admit the penumbra problems that inevitably surface in our legal system.[78] As Hart explains, such a rigid view of the law is considered to be an inaccuracy of the original thesis because it is erroneous to think that the reasoning involved in a judicial decision is deduced from premises that are not influenced by the judge's "practical choices or decisions".[79]

When we consider the issue of whether organs and tissue are property for the purposes of post-mortem donation, I suggest we think of it in terms of a penumbra problem. At the law's core of settled meaning are Honoré's incidents of ownership. And so, while certain features of Honoré's incidents of ownership are apparent in human body parts, by way of Hart's approach, judges need not apply any of these elements as strict principles that are always necessary for finding an enforceable ownership right. To make sound determinations about penumbra problems such as this, judges could – and, according to positivists like Hart, *should* – consider the issue "in light of

[69] Ziff, *supra* note 5 at 2.
[70] J. Bentham, *The Theory of Legislation* (Bristol: Thoemmes Pr., 2004 ed., 1802) vol. 1 at 113 as cited by Ziff, *supra* note 5 at 2.
[71] Ziff, *supra* note 5 at 2.
[72] H.L.A. Hart, "Positivism and the Separation of Law and Morals" (1958) 71 Harvard Law Review 593 at 607.
[73] *Ibid*.
[74] *Ibid*.
[75] *Ibid*.
[76] *Ibid* at 608.
[77] *Ibid*.
[78] *Ibid*.
[79] *Ibid*.

social aim."[80] While Hart recognizes that law and morality interact with each other, he is careful not to find morality as a necessary element of something that is legally enforceable (such as a right or a claim).[81] As Hart explains, "the intelligent decision of penumbral questions is one made not mechanically but in the light of aims, purposes, and policies, though not necessarily in the light of anything we would call moral principles."[82]

Thus, if we pause to imagine a court being confronted with the issue of whether we have personal property ownership in our body parts after we die, we are standing in the penumbra of property law and asking the court to tell us if the juridical definition of personal property applies to body parts in the post-mortem context. And, since the legal definition of property is understood as being a right to a thing, we are really asking the court to determine whether living persons have the right to be able to control the fate of their body parts after death, much like their right to make testamentary dispositions concerning other kinds of property.

When we examine the penumbra problem again with these thoughts fresh in mind, we see that it is indeed tricky to conclusively demonstrate how legal positivism supports personal property ownership (i.e. a legally enforceable claim) to our body parts. This is so because Hart's legal positivism is more concerned with offering an accurate description of the legal system's process for establishing law than it is with validating or invalidating laws on moral grounds.[83] Still, invoking Hart's legal positivist theory is useful because it helps identify post-mortem body parts as a penumbra problem that can fall very well within the ambit of property law.

Our discussion of Honoré's incidents of property shows to some extent there has already been legal recognition, albeit indirectly, of some personal ownership in our body parts, at least whilst we are alive and whilst our parts are attached to our person. The law has enforced these property rights by establishing various rules for how we govern our bodies and how the state can (and cannot) govern our bodies. As discussed earlier in Chapter 1, time and technology have encouraged the common law to evolve on questions and claims of property in body parts. Recent case law like *Lam*[84], *C.C. v A.W.*[85] and *Re JS*[86] put the self-ownership question into the penumbra. These cases and the legal questions they answer weigh in favour of property rights being in line with what the law ought to be, precisely because these questions are in the penumbra, consistent with Hart.

The common law continues to expand and show us that individual autonomy, informed consent, and life, liberty and security of the person are values that must be recognized and respected when determining legal questions about the human body and body parts. However, at the core of our donation system sits legislation that does not totally align with these values. The result is a legislative framework that stands in the way of where the common law ought to go with respect to post-mortem organ donation. Meaningful reform is therefore necessary to move the core of our organ donation law so that it aligns with those aforementioned values; values that we have come

[80] *Ibid* at 611.
[81] Starr, *supra* note 53 at 687.
[82] Hart, *supra* note 72 at 614.
[83] Starr, *supra* note 53 at 688.
[84] *Lam v University of British Columbia*, 2013 BCSC 2094, 20 BLR (5th) 139; aff'd 2015 BCCA 2, [2015] 4 WWR 213.
[85] *C.C. v A.W.*, 2005 ABQB 290, 50 Alta LR (4th) 61.
[86] *Re JS*, [2016] EWHC 2859 (Fam).

to recognize as paramount in our society. The current donation framework appears to fly in the face of these advancements and continued enforcement of the same antiquated donation model is inconsiderate of the historical, social and legal grounds that should be encouraging meaningful reform.

Conclusion

In this chapter I have aimed to show that property rights in the post-mortem donation process can be substantiated by dominant (and sometimes conflicting) theories of private property. As previously discussed, modern medicine has made organ and tissue transplantation a viable and lifesaving form of medicine. Imbuing organs and tissue with principles of property law should guide legislatures toward constructing a framework that not only respects individual autonomy by codifying recorded post-mortem instruction (i.e. protecting a deceased's instruction to donate or to refrain from donating), but also answers the need for increased donations by facilitating the donation process in instances where post-mortem instruction was not left. Have other countries been more successful in achieving this balance? The next chapter of this thesis examines what successes, if any, other countries have experienced by employing a mandated choice or presumed consent system of organ donation.

CHAPTER 4
Other Donation Frameworks

As we saw in Chapter 1, provincial donation laws are uniformly entrenched in altruism and have taken the form of "opt-in" donation models. As discussed, dependency on this notion of altruism is problematic because in most cases families become empowered as the ultimate decision makers over whether an individual's body parts are donated after death, and this form of substitute decision-making is regularly engaged irrespective of the deceased's prior given intent. The result is a donation framework that violates donor autonomy whilst undermining the serious need for increased donations.

To meaningfully address the need for increased donations, a successful provincial framework must turn its attention to the thousands of potential donors who die each year without donating their organs and tissue. Part 1 of this chapter contrasts presumed consent and mandated choice schemes to consider whether this aim is being achieved under these different frameworks. As we will see, common unease surrounding notions of "default" have marred the public's acceptance of these types of donation systems in Canada. However, through an overview of regional case studies, Part 2 of this chapter will argue that even though family input and other variables can indeed impact a presumed consent model's effect on donation rates, it is ultimately the default mechanism of that opt-out framework that is the key distinguishing feature placing presumed consent above other donation models.

4.1 Presumed Consent & Mandated Choice

Presumed consent, which is sometimes referred to as the "opt-out" system, hypothetically functions as a donation framework under which our consent to donate would be presumed unless we explicitly opt out. Under presumed consent legislation, individuals are considered to be post-mortem donors unless they explicitly rebut the presumption to donate, which is typically done by way of a notation on their driver's licence.[1] In light of ongoing organ shortages across the developed world, presumed consent has found itself at the centre of heated debates concerning how the state should adequately respond to society's increasing need for donor organs and tissue.

Mandated choice, on the other hand, is a donation framework that requires a person to register a decision concerning post-mortem donation. American lawyer, Haley Cotter, has described this framework as follows:

> …mandated choice, a system in which individuals are prospectively required to register their intentions to donate or not to donate their organs when they die. These registered choices are legally binding upon the individual's death. Mandated choice differs from the current system of organ donation in which many individuals die without expressing a legally enforceable decision regarding organ donation.

[1] Cass R. Sunstein & Richard H. Thaler, "Libertarian Paternalism Is Not an Oxymoron" (2003) 70:4 Chi L Rev 1159 at 1191. See also: A. Abadie & S. Gay, "The impact of presumed consent legislation on cadaveric organ donation: a cross-country study" (2006) 25:4 J Health Econ 599 at 599.

> Mandated choice has the potential to increase the organ supply while maintaining individual autonomy and preserving informed consent."[2]

Use and study of the mandated choice donation framework is lacking compared to presumed consent. Other than the following Texas and Illinois examples, my research has not uncovered any other setting where mandated choice has been tested or explicitly enacted. In theory, the 2006 Alberta framework had the appearance of a mandated choice system, but we will recall from our discussion in Chapter 1 that the Alberta framework relies largely on substitute decision-making, so much so that family are informed about – and must agree to – the deceased's prior recorded consent.[3] Hence, the American examples that follow must suffice for the purposes of this mandated choice analysis.

a) Mandated Choice: Case Studies

In 1991, Texas briefly attempted to enact mandated choice legislation. The state required people to register a donative intention as part of the driver's license renewal process.[4] However, the law was not actually enforced, as "license registry employees often did not even ask individuals the questions about organ donation."[5] Consequently, people renewing their driver's license could still do so without having to record an answer, and those who refused to answer or were not asked the question were registered as if they had responded "no" to organ donation.[6] Upon death, the deceased's family could not override this "no" and this system resulted in an eighty percent refusal rate and a corresponding drop in organ donation.[7] The law was subsequently repealed in 1997.[8]

Beyond the Texas example, Illinois' system has been referred to as a mandated choice system,[9] although I would argue that this is a misclassification and it is an opt-in model in every sense. The 2006 enactment of the First Person Consent Organ/Tissue Donor Registry is an opt-in model for people wishing to record their donative intent. Corresponding government legislation is said to solidify these registrations so that they are legally binding regardless of any opposition from family.[10] The Illinois Organ/Tissue Donor Registry provides as follows: "First Person Consent makes your decision to be an organ/tissue donor legally binding. Additional witnesses or family consent is no longer required; your wishes will be honored."[11] First person consent stems from an update to the American Uniform Anatomical Gift Act (UAGA) in 2006, and as of 2015 it was

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[2] Haley Cotter, discussing criticism of mandated choice. See Haley Cotter, "Increasing Consent for Organ Donation: Mandated Choice, Individual Autonomy, and Informed Consent" (2012) 21:2 Health Matrix 599 at 607.
[3] My Health Alberta, "Organ and Tissue Donation in Alberta", online: <https://myhealth.alberta.ca/alberta/Pages/organ-and-tissue-donation-faqs.aspx>.
[4] Cotter, *supra* note 2 at 618 citing Joseph L. Verheijde *et al.*, "Recovery of Transplantable Organs After Cardiac or Circulatory Death: Transforming the Paradigm for the Ethics of Organ Donation" (2007) 2:8 Phil Ethics & Human Med 8.
[5] Cotter, *supra* note 2 at 618 discussing criticism of mandated choice and citing Susan E. Herz, "Two Steps to Three Choices: A New Approach to Mandated Choice" (1999) 8 Cambridge Q Healthcare Ethics 340 at 342.
[6] Cotter, *supra* note 2 at 618.
[7] *Ibid*.
[8] *Ibid* at 619.
[9] *Ibid* at 622.
[10] *Ibid* at 621. See also Illinois Secretary of State, *First-Person Consent Fact Sheet* (31 January 2011), online <https://www.lifegoeson.com/publications/pdf_publications/ex73.pdf>.
[11] Illinois Secretary of State, "LifeGoesOn.com: Illinois Organ/Tissue Donor Registry", online: <https://www.ilsos.gov/organdonorregister/>.

adopted by Puerto Rico and all but three American states.[12] According to Kristopher T. Starr, American lawyer and registered nurse, the 2006 UAGA "…explicitly specified direct written or actual consent declarations" and "[d]esignation on one's driver's license, by a donor card, or in a testamentary or advance directive document all set the standard for consented, predeath donor intent to donate under the 2006 UAGA". According to Starr, in the 47 states that have adopted the 2006 UAGA, the donor's clearly published intent will be followed, even if the family's view conflicts with the donor's intent.[13] Under the 2006 UAGA, next of kin still have a role to play: where a deceased did not leave donative intent, family can consent or refuse to consent.[14]

My research has not uncovered any elements of a mandated choice framework within Illinois' revised post-mortem donation system. According to Starr, the 2006 UAGA revision "…explicitly specifies direct written or actual consent declarations"[15] as being necessary to effect post-mortem donation, and the First Person Consent Registry (as previously noted) aims to facilitate and bind the explicit intent of donors and non-donors. That said, citizens of Illinois are not required to make a choice about organ donation and therefore the model has yet to depart from an opt-in structure.

Nevertheless, it is worth noting that since the 2006 UAGA was adopted in Illinois and the First Person Consent Organ/Tissue Donation Registry was developed, approximately 60% of adults in Illinois have registered as donors.[16] Moreover, the number of deceased organ donors has increased by 40%, from approximately 300 deceased donors in 2006 to 500 deceased donors in 2019.[17] In light of this growth, however, the Gift of Hope Organ & Tissue Donor Network (a federally designated not-for-profit organ procurement organization in the United States) estimates that more than 200 people will die in 2020 while waiting for a transplant in Illinois.[18] This deficiency reinforces our observations made earlier in Chapter 1 concerning the Alberta model. Specifically, it demonstrates that although opt-in (registration) systems can increase registration rates, any corresponding increase in donations has remained a drop in the bucket compared to the growing need for organs and tissue.[19]

b) Presumed Consent: Case Studies

Singapore and much of Europe's post-mortem donation is based on a presumed consent model, including the countries of Austria, Belgium, Denmark, Finland, France, Italy, Luxembourg, Norway, Slovenia, Spain and Wales, to name a few.[20] However, like the opt-in model of Saskatchewan, the presumed consent model also allows for families to have the final decision on

[12] Kristopher T. Starr, "Can the family block organ donation", (2005) 45:5 Nursing 16 at 16. As Starr notes, Delaware, Pennsylvania and New York had not adopted the UAGA as of 2015.
[13] *Ibid*.
[14] *Ibid*.
[15] *Ibid*.
[16] Gift of Hope Organ & Tissue Donor Network, "About Us: Trends & Waiting Lists", online: <https://www.giftofhope.org/trends-waiting-lists/> [Illinois Donor Network].
[17] U.S. Department of Health and Human Services, "Organ Procurement and Transplantation Network: State Data (Illinois)", online: <https://optn.transplant.hrsa.gov/data/view-data-reports/state-data/>.
[18] Illinois Donor Network, *supra* note 16.
[19] *Ibid*.
[20] Sunstein & Thaler, *supra* note 1 at 1191. For a list of other countries with a presumed consent structure see Lee Shepherd *et al.*, "An international comparison of deceased and living organ donation/transplant rates in opt-in and opt-out systems: a panel study" (2014) 12:131 BMC Medicine 1 at 4 (Table 1) .

whether a deceased's organs will be donated.[21] I cannot find any exceptions to the general practice of allowing families to have the final decision in presumed consent systems. The literature seems to suggest this is the normal trend in presumed consent procurements.[22] Data does not specify what type of consent ultimately triggered the donation in presumed consent countries (i.e. whether the presumption of consent led to the donation or whether the family agreeing to the presumption led to the donation). My research did not uncover statistics of this nature. Providing families with ultimate decision-making power is often the case in European countries and as we discussed in Chapter 1, Nova Scotia's presumed consent law is shaping up to employ this same process as well. Despite this trend among presumed consent jurisdictions, some scholars have argued that legislative defaults still have a marked effect on people and their families donate.[23]

In a 10-year study conducted between 1993 and 2002 (the "2003 study), researchers looked at 22 countries over that period and considered a variety of factors that could contribute to increased donation rates within a presumed consent model.[24] Those determinants included but were not limited to the dominant religion in the country, GDP, healthcare funding, and the higher number of brain deaths recorded in presumed consent countries.[25] The study found that much of the variation in donation rates are explained by the differences in these "determinants of organ donation", but ultimately "presumed consent legislation has a positive and sizeable effect on organ donation rates."[26] The 2003 study observed that most studies before it have consistently observed that opt-out systems are rarely enforced and family consent has always been required under presumed consent laws.[27] Where presumed consent is not enforced and families are approached, the 2003 study argues that the default mechanism may affect the final determination of families and could generate a sizeable increase in donors as compared to rates under an opt-in system.[28] This assessment is supported by a separate 2003 study in which investigators analyzed the default mechanism by comparing opt-in and opt-out trends across presumed consent and informed consent (opt-in) countries.[29] This subsequent study reported that only 28% of Americans elect to opt in to donation, whereas over 90% of people in presumed consent nations leave themselves available to post-mortem donation.[30]

It is important to note that these statistics have not translated into a marked increase in actual post-mortem donations. As some scholars have asserted, "…there are no clear examples of countries with a real sustained increase in organ donation after modifying the law" from an opt-in to an opt-out framework.[31] It is also worth noting that the opt-out frameworks of France and Brazil have had

[21] Abadie & Gay, *supra* note 1 at 600.
[22] See Alexandra Glazier & Thomas Mone, "Success of Opt-In Organ Donation Policy in the United States" (2019) 322:8 JAMA 719 at 720 for the point that "…opt-out countries will not proceed with organ donation over family objection."
[23] Abadie & Gay, *supra* note 1 at 600. See also Hendrik P. van Dalen & Kene Henkens, "Comparing the effects of defaults in organ donation systems" (2014) 106 Social Science and Medicine 137; Sunstein & Thaler, *supra* note 1.
[24] Abadie & Gay, *supra* note 1.
[25] *Ibid* at 608.
[26] *Ibid* at 599.
[27] *Ibid* at 613.
[28] *Ibid* at 612 and footnote 31.
[29] Sunstein & Thaler, *supra* note 1.
[30] *Ibid* at 1192.
[31] Rafael Matesanz & Beatrix Domínguez-Gil, "Opt-out legislations: the mysterious viability of the false" (2019) 95:6 Kidney Int 1301 at 1301.

negative effects on donation rates, which some scholars attribute in part to the public's "increased levels of mistrust towards medical professionals."[32] This may stem from a notion that, under a presumed consent system, doctors are partial to the interests of other patients who may benefit or recover from a transplant made available by the critically ill. Some may argue that a default donation system could lead doctors to reduce life sustaining treatment and call 'time of death' prematurely in order to improve the lives of other patients. Despite this concern and its effect on France and Brazil, the majority of the aforementioned studies suggest that the default mechanism can contribute significantly to establishing a larger pool of potential donors. [33] Moreover, these studies further suggest that it may be possible to significantly increase post-mortem donation rates by enforcing presumed consent legislation so that potential donors (i.e. deceased individuals who have not opted-out) become actual donors.

c) Attitudes Toward Default Presumptions and Mandated Choices

It has been said that the opt-in model generates less registered donors because it depends on "spontaneous forms of altruism", which must compete against attitudes of apathy and procrastination.[34] In the alternative, systems of mandated choice and presumed consent have been highlighted as better options for increasing deceased donor statistics. Generally speaking, studies have found that, "…the mainly Catholic countries of Central and Southern Europe, with a legal system strongly based in Roman law, have opting out/presumed consent systems and an emphasis on the citizen's duties to the state; whereas the largely protestant countries of Northern Europe rely more on common law, and place more emphasis on individual rights of determination."[35] Researchers have also studied the attitudes toward default systems in opt-in countries to get a better understanding of how changes to default organ donation frameworks might be received.

In a 2011 national survey of 2069 respondents in the Netherlands (the "2011 Netherlands Survey"), respondents were given hypothetical choices regarding defaults in organ donation systems. The survey was provided to people aged 16 and older – and the response rate was 77%.[36] The survey objective was "to test for differences in choices across donation systems."[37] The pool of respondents was divided into four groups, so that four different donation regimes could be compared, being (1) explicit consent/opt-in; (2) presumed consent; (3) mandated choice; and (4) a neutral system "in which respondents were asked whether they would be willing to become an organ donor."[38]

Group 1, explicit consent, was asked: "Suppose you move to another province where the donor system is such that you are not automatically an organ donor. You have to explicitly register as a donor. What would you do?".[39] The options for response were "(a) I will leave it as it is and not

[32] Shepherd *et al.*, *supra* note 20 at 11.
[33] Sunstein & Thaler, *supra* note 1 at 1192. See also Matesanz & Dominguez-Gil, *supra* note 31; Shepherd *et al.*, *supra* note 20; Glazier & Mone, *supra* note 22; and Amber Rithalia *et al.*, "Impact of presumed consent for organ donation on donation rates: a systemic review" (2009) 338:7689 BMJ 284.
[34] van Dalen & Henkens, *supra* note 23 at 137.
[35] S. Cameron & J. Forsythe, "How can we improve organ donation rates? Research into the identification of factors which may influence the variation" (2001) 21:5 Nefrologia 68 at 72. See also Abadie & Gay, *supra* note 1 at 607-608.
[36] van Dalen & Henkens, *supra* note 23 at 138.
[37] *Ibid* at 138.
[38] *Ibid*.
[39] *Ibid*.

become a donor; (b) I will register as a donor; and (c) Don't know.[40] 50% of respondents said they would register as a donor.[41]

Group 2, presumed consent, was asked: "Suppose you move to another province where the system is such that you are automatically a donor, unless you explicitly object. What would you do?"[42] The options for response were "a) I will leave it as it is and become automatically a donor; (b) I will object and will not become a donor; and (c) Don't know."[43] The survey found that the number of registered donors would increase from a 50% donation rate in an explicit consent system by approximately 12% under a presumed consent system, thereby amounting to a 62% donation rate under a presumed consent system.[44] The conclusion drawn by the authors is that "reform in the direction of a presumed consent system would be an improvement."[45]

Group 3, mandated choice, was asked: "Suppose that every time you have to renew your passport at the local municipality you are also obliged to make a choice with respect to organ donation. In case you will renew your passport in the coming week what will be your response with respect to the question 'Do you want to be an organ donor?'"[46] The options for response were "(a) Yes, and (b) No."[47] The results determined that 66% of respondents would agree to become a donor.[48] The survey authors therefore conclude that a mandated choice system would result in "a substantial increase in the number of donors."[49]

Group 4 was asked the neutral question, "Are you willing to become an organ donor".[50] The options for response were (a) Yes, I want to become a donor and; (b) No, I don't want to become a donor; and (c) I don't know and I will delegate this decision to my relatives."[51] The authors of this survey note that this question can be interpreted "as a 'softer' version of the mandated choice setting where the decision maker can opt to have the next-of-kin decide."[52] 57% of respondents in group 4 expressed a "willingness to become a donor", which signals that the explicit consent [opt-in model] produces too few donors.[53]

Of note, all respondents from each group were asked if they were officially registered as an organ donor.[54] The goal of this question was to "to study in depth the way actual donor choices are in line with donation behavior across donor systems."[55] Investigators determined that 90% of people who

[40] *Ibid*.
[41] *Ibid* at 139.
[42] *Ibid* at 138.
[43] *Ibid*.
[44] *Ibid* at 139.
[45] *Ibid*.
[46] *Ibid* at 138.
[47] *Ibid*.
[48] *Ibid* 139.
[49] *Ibid*.
[50] *Ibid* at 138.
[51] *Ibid*.
[52] *Ibid* at 139.
[53] *Ibid*.
[54] *Ibid*.
[55] *Ibid*.

told researchers they would donate in their particular regime were in fact registered to donate.[56] By "registered to donate", the survey authors are referring to the status of individuals that have either opted in by consenting to donate or that have refrained from opting out if they live in a presumed consent country. The survey authors conclude that these findings suggest that registered donors "do not actually change their mind in a different donor regime" and that non-registered donors do change their mind depending on the donation regime in place.[57] In this way, the authors hypothesize that the donation rate for non-registered donors would be considerably higher under a presumed consent system and a mandatory choice regime, as compared to an opt-in system.[58]

Interestingly, the survey results also showed that a substantial percentage of respondents did not have clear preferences.[59] The authors observed that undecided respondents in an opt-in model cause the number of registered donors to remain the same (50%), but the number of registered donors under a presumed consent system increases the donation rate by 12%, for a total donation rate of 62% under a presumed consent system.[60] In addition to that, 20% of respondents said they do not know if they would stay registered under a presumed consent system.[61] This undecided pool has the potential to move the presumed consent donation rate as high as 82% if they decide to stay registered or if their indecision prevents them from opting out before they die. The overall conclusion drawn by the 2011 Netherlands Survey is that the default mechanism of presumed consent and the "positive obligation component" of mandated choice could generate registered donors more effectively than the current opt-in model.[62]

In the Canadian context, findings from a 2010 survey on organ donation ("the 2010 Canadian survey") concluded that only a slight majority of Canadians approved of a default donation system even though 95% of respondents said they approve of organ donation.[63] More specifically, 54% of polled Canadians were in favour of presumed consent.[64] Of the 1,500 randomly selected respondents aged 18 years and older, the default donation system is less appealing even in light of the strong attitudes that favour donation generally (69% strongly approve of it and 26% somewhat approve).[65]

The 2010 Canadian survey also found that 51% of respondents decide to donate their organs ("decided donors"), while a significant number of respondents (42%) remain undecided, and 7% said they will not donate.[66] Of the 7% of respondents that have decided not to donate, 6% cited that they do not like the thought of donating and 3% cited a preference to keep their organs, tissue, or bodies intact.[67]

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[56] *Ibid*.
[57] *Ibid*.
[58] *Ibid*.
[59] *Ibid*.
[60] *Ibid*.
[61] *Ibid*.
[62] *Ibid* at 137. The opt-in model is also referred to as the explicit consent model.
[63] Ipsos Reid, "Views Toward Organ and Tissue Donation and Transplantation: Final report" (10 July 2010) at 4, online: <https://professionaleducation.blood.ca/sites/msi/files/Views-Toward-OTDT-Final-Report-2010-07-221.pdf>.
[64] *Ibid* at 6.
[65] *Ibid* at 4.
[66] *Ibid*.
[67] *Ibid* at 16.

Of the slight majority that said they were decided donors, the survey also asked if they "have taken certain official and unofficial steps to express or register their intention to donate."[68] In the result, 84% of decided donors said they have discussed their wishes with next of kin; 78% of decided donors have signed a donor card and 76% have discussed their decision with their medical advocate.[69] Of that latter group, 59% feel very confident that their advocate will exercise the decision,[70] whereas over 40% lacked confidence that their wishes would be carried out. Just over half of decided donors (57%) have registered their consent through their health card and only 27% have recorded their name on a registry.[71] Moreover, "respondents were asked to rate the importance of several principles in light of a national system for organ and tissue donation in Canada.[72] The top principle was "ensuring that all Canadians have a fair chance of receiving an organ or tissue transplant."[73]

More recently, a 2019 Saskatchewan study conducted by the University of Saskatchewan's Social Sciences Laboratories surveyed 400 Saskatchewan residents about organ donation.[74] Of those surveyed, 84% of respondents said they somewhat agreed or strongly agreed that the province should implement a presumed consent system for organ donation.[75] Like the 2011 Netherlands Survey, results from the Saskatchewan survey and the 2010 Canadian survey suggest that the default mechanism of presumed consent (and perhaps the positive obligation component of the mandated choice regime) could generate registered donors more effectively in Canada than the current opt-in model. The opt-out system is apt to satisfy the slight majority of people that are in favour of presumed consent and could also garner additional donors from that strong majority (95% of surveyed respondents) that approve of organ donation generally. With these survey results in mind, the following sections will consider if –and to what extent– presumed consent models are successful at increasing registered donor rates in countries that already have this default system implemented.

d) Rebuttable Presumption & Family Veto

Research evidences that even in countries where presumed consent is in place, families can still easily rebut the presumption of consent by simply objecting to the donation.[76] In the presumed consent nations of Spain, Croatia and Portugal, family override provisions are still in play and yet these countries continue to be the most successful in Europe.[77] Under Spain's presumed consent

[68] *Ibid* at 4.
[69] *Ibid*.
[70] *Ibid*.
[71] *Ibid*.
[72] *Ibid* at 26.
[73] *Ibid*.
[74] University of Saskatchewan Social Sciences Research Laboratories, "Taking the Pulse Saskatchewan", online <https://ssrl.usask.ca/taking-the-pulse.php>. See also Andrea Hill, "Taking the Pulse: 84 per cent of Sask. Residents want presumed-consent organ donation" (3 July 2019) online: *Saskatoon StarPhoenix* <https://thestarphoenix.com/news/local-news/taking-the-pulse-84-per-cent-of-sask-residents-want-presumed-consent-organ-donation>.
[75] *Ibid*.
[76] van Dalen & Henkens, *supra* note 23 at 137; G.T. Laurie *et al., Mason and McCall Smith's Law and Medical Ethics*, 10th ed (Oxford, United Kingdom: Oxford University Press, 2016) at 601; M. Rosenblum *et al.*, "The authority of next-of-kin in explicit and presumed consent systems for deceased organ donation: an analysis of 54 nations" (2012) 27:6 Nephrol Dial Transplant 2533.
[77] Laurie *et al., supra* note 76 at 601. See also J. M. Martinez *et al.*, "Organ donation and family decision within the Spanish donation system" (2001) 53:4 Soc Sci Med 405.

framework, individuals are able to "express a desire to be a donor in addition to a method [for] objecting to deceased donation".[78] The next-of-kin's authorization is required if the deceased's wishes are unknown and presumed donation can be vetoed by the next-of kin.[79] Similarly, in Columbia and Costa Rica, next-of-kin hold significant authority under these presumed consent frameworks. In these two nations, 'presumed consent' is practiced only if the next-of-kin cannot be reached.[80]

Several studies have explored various factors that affect substitute decisions, including socio-economic factors, understanding brain death, religion, quality of procurement requests, and so on.[81] Of all factors considered, one study found that "the living will of the deceased is the most important single factor for decision."[82] The "living will" concept stems from Sweden's legislation, the *Transplant Act* of 1995, and amounts to the deceased's prior wish concerning post-mortem organ donation.[83] Under Swedish legislation, an individual expresses their living will by registering in the national organ donation registry, signing a donor card or informing family of their wishes.[84] As authors of a 2007 Swedish study advise, we should not view the living will as a factor in the families' decision since Swedish law intends for the deceased's prior wish to settle the decision.[85] In this way, the living will is intended to serve as binding first person consent but the study suggests that family is still asked about donation even where the deceased had already decided themselves.[86] Where the deceased's consent was known, the study found that the family agreed to the donation request 100% of the time.[87] Where the deceased did not express wishes during life, the family is approached to either veto or consent to the donation presumption. In those instances, it is estimated that family will override the presumption 40% to 50% of the time.[88]

Medical literature has consistently found that "public education is needed to modify attitudes about organ donation… [in order to] maximize the opportunity to persuade families to donate their relatives' organs."[89] Despite family involvement in presumed consent systems, nations with the opt-out model have shown statistically higher deceased donation rates than nations with opt-in

[78] Rosenblum *et al.*, *supra* note 76 at 2542 (Table 2) footnote a.
[79] *Ibid* at 2542 (Table 2).
[80] *Ibid*.
[81] Margareta A. Sanner, "Two perspectives on organ donation: experiences of potential donor families and intensive care physicians of the same event" (2007) 22 Journal of Critical Care 296 at 297. See also W. DeJong *et al*., "Requesting organ donation: an interview study of donor and nondonor families" (1998) 7 Am J Crit Care 13; H.G. Franz *et al*., "Explaining brain death: a critical feature of the donation process" (1997) 7 J Transpl Coord 14; J. Rosel *et al*., "Discriminant variables between organ donors and nondonors: a post hoc investigation" (1999) 9 J Transpl Coord 50; Laura A. Siminoff *et al*., "Factors Influencing Families' Consent for Donation of Solid Organs for Transplantation" (2001) 286:1 JAMA 71; Samantha J. Anthony *et al.*, "Family veto in organ donation in Canada: framing within English-language newspaper articles" (2017) 5:4 CMAJ E770.
[82] Sanner, *supra* note 81 at 297.
[83] *Ibid* at 296.
[84] *Ibid*.
[85] *Ibid* at 297 (footnote 1).
[86] *Ibid* at 301, Table 5.
[87] *Ibid* at 301.
[88] *Ibid* at 296.
[89] Siminoff *et al*. *supra* note 81 at 71. See also: Franz *et al*., *supra* note 81; W. DeJong *et al*., *supra* note 81; J. Rosel *et al*., *supra* note 81.

models.[90] Despite the practice of asking relatives if they are in favour of donation,[91] Spain has the world's highest rate of organ donation, with 47 deceased donors per million population in 2017.[92] That same year, the United States saw 31.7 deceased donations per million population and Canada saw only 21.9 per million population.[93] Presumed consent nations, generally speaking, average about 17.29 deceased donors per million population per year.[94] Compared to the annual average in informed consent counties, which is said to be about 14.19 deceased donors per million population per year, there is a difference of 3.10 donors per million population in presumed consent countries,[95] which is actually an impressive statistic if we consider that this translates into a 21.84 per cent increase. With this in mind, it has been suggested that presumed consent could actually lead to a 25-30 per cent jump in post-mortem donations in nations that currently have opt-in models.[96] However, the caveat to any estimates concerning potential increase is the fact that there are substantial differences in how presumed consent legislation has been enforced across European countries.[97] Statistics will therefore vary across presumed consent countries if the default "yes" is accompanied by nation-specific exceptions and practices such as transplant coordination teams, donation campaigns, physicians' approaches to requesting donations from families, and other factors that will be discussed in the next section.

e) Beyond the Presumption: Underlying Variables Affecting Donation

While the effects of Spain's default donation system have been shorter transplant wait lists and less reliance on *inter vivos* organ and tissue donation, it would be wrong to assume that the default 'yes' is solely responsible for increased donation rates in countries like Spain.[98] A 1992 survey showed that, in England, organizational failures were deemed to be the cause of more than half of potential donors failing to become actual donors.[99] And despite an overall high donation rate, a 1996 Spanish survey showed similar rates of "causes for lost donations".[100] These studies suggest that organizational elements and procedures impact the efficacy of presumed consent legislation. For example, accompanying Spain's presumed consent legislation is a "…dedicated transplant co-ordination team, largely made up of part-time paid doctors and nurses"[101] that contributes to Spain's higher donation rates. When Tuscany introduced its transplant coordination system, which

[90] Rosenblum *et al.*, *supra* note 76 at 2541; Abadie & Gay, *supra* note 1.
[91] Cameron & Forsythe, *supra* note 35 at 73.
[92] Beatriz Dominguez-Gil & Rafael Matesanz, eds., "Newsletter Transplant: International figures on donation and transplantation (2017)" 23:1 (September 2018) at 44. See also David Rodriguez-Arias *et al*. "Success factors and ethical challenges of the Spanish model of organ donation" (2010) 376:9746 The Lancet 1109 at 1109.
[93] Dominguez-Gil & Matesanz, *supra* note 92 at 45 and 46.
[94] The 17.29 percent average comes from a sample study of cadaveric (deceased) donation rates in 2002 across 23 presumed consent countries. See Abadie and Gay, *supra* note 1 at 607.
[95] The 14.19 percent average comes from a sample study of cadaveric (deceased) donation rates in 2002 across 13 informed consent countries. See Abadie & Gay, *ibid* at 607 and 613.
[96] This potential increase in donation is estimated in the American and U.K. contexts and assumes that "percentage increases in cadaveric donations translate roughly for percentage increases in cadaveric transplantation". See Abadie & Gay, *ibid* at 612.
[97] Limits on access to data have challenged attempts at describing the various effects of presumed consent legislation across different countries. See Abadie & Gay, *ibid* at 612, footnote 31.
[98] Rosenblum *et al.*, *supra* note 76 at 2534; Laurie *et al.*, *supra* note 76 at 601; Martinez *et al.*, *supra* note 77; Abadie & Gay, *supra* note 1; Cameron & Forsythe, *supra* note 35.
[99] Cameron & Forsythe, *supra* note 35 at 73.
[100] *Ibid* at 73.
[101] *Ibid* at 74.

was based on the Spanish system, it saw the national donation rate double to 13.5 donors per million population within a year and a half after implementation.[102]

Other variables that have also been attributed to the higher donation rates in presumed consent countries are initiatives aimed at promoting positive attitudes concerning organ donation as well as the training of medical practitioners involved in the organ procurement process, both of which are said to be important factors to increasing organ donation rates.[103] Statistics suggest that a physician's approach to requesting donation from families significantly impacts whether potential donors become actual donors. The 2007 Swedish study that I referenced earlier in this chapter determined that pro-donation approaches resulted in higher instances of family consenting to donation. The study reviewed the physicians' approach related to donation outcome in 14 cases where the deceased's wishes were unknown. The investigator found that a pro-donation approach was applied in seven of those cases and in all seven instances the families decided in favour of donating.[104] Where physicians took a neutral or ambivalent approach in the other 7 cases, the families decided against donation.[105] The investigator concludes that physicians who cannot exercise a pro-donation approach "should perhaps be excused from this task."[106]

A 2001 Spanish study has since analyzed 68 different cases where families were tasked with giving or denying consent and investigators determined a number of different variables that impact family decision-making when approached for consent.[107] Family decisions appeared to be most affected by apparent knowledge of the deceased's thoughts or wishes about organ donation.[108] Other variables at play, from strongest to weakest, were: "family relationship climate"; the family's level of satisfaction with received medical attention; and the number of family members present when consent was requested.[109] These studies, like the Swedish study noted earlier, suggest the expressed wishes of a potential donor are paramount,[110] and that the default can serve as the deceased's donative intent if the family is convinced that the deceased could have opted out but intentionally chose to stay enrolled as a donor. Put simply, "legislative defaults affect the decisions of potential donors and families."[111]

4.2 The Default Mechanism

Default rules for organ donation have been proven to impact donor consent rates. The results from the 2010 Canadian Survey and 2011 Netherland Survey, as discussed earlier in this chapter, suggest that legislation to institute presumed consent or mandated choice would be more effective at generating post-mortem donors than the opt-in framework.[112] But why do these legislated defaults make such a difference? Literature from the fields of medicine, behavioural economics and

[102] *Ibid* at 74.
[103] Martinez *et al*., *supra* note 77 at 405 and 416.
[104] Sanner, *supra* note 81 at 301.
[105] *Ibid*.
[106] *Ibid* at 304.
[107] Martinez *et al*., *supra* note 77 at 405.
[108] *Ibid*.
[109] *Ibid*.
[110] *Ibid* at 405 and 416.
[111] Abadie & Gay, *supra* note 1at 600.
[112] Van Dalen & Henkens, *supra* note 23 at 137.

psychology have long explored the effect that defaults have on individual choices.[113] In studying defaults within the organ donation context, studies show that there were more registered donors in opt-out countries (presumed consent) than there were in opt-in countries.[114] One reason for this variation is because opting out of a presumed consent model is considered relatively onerous. The forms, phone calls and mailing of paperwork required to effectively opt out deters people from 'going to the bother' of opting out; hence, more people remain on the donor registry of a presumed consent country.[115] On the other hand, more people remain off the donor registry in an opt-in country,[116] and this is the case even in countries where surveys show deceased donor intent to be strong.

Regardless of donor preference, consent rates tend to remain low where the legislated default is the opt-in framework.[117] By way of example, the Netherlands instituted a national donor registry in 1998 and its creation involved widespread campaigning.[118] Over 12 million letters were sent out to encourage citizens to donate their organs.[119] In a country of 15.8 million at that time, the expectation was to increase the rate of donors, but the opt-in rate did not change.[120]

Where deceased donor rates are higher in opt-out rather than opt-in countries, the fairly obvious deduction to be made is that defaults will have a considerable role to play on the large pool of "potential donors" who are indeed in favour of donation but do not get around to making the decision to become actual donors. Defaults have been viewed as useful, particularly when compared to the mandated choice model, because the default mechanism of presumed consent theoretically allows people to avoid making the unpleasant decision about organ donation.[121] In this line of thought, it follows that since decisions are easier to make under the presumed consent model, and since most people appear to be in favour of donation, donation rates are said to increase since the default decision is donation.

The default mechanism of the presumed consent model is said to impose "physical, cognitive, and, in the case of donation, emotional costs on those who must change their status."[122] As one study suggests "…defaults can lead to two kinds of misclassification: willing donors who are not identified or people who become donors against their wishes"; however, it also observes that "[t]he tradeoff between errors of classification and physical, cognitive, and emotional costs must be made with the knowledge that defaults make a difference in lives saved through transplantation."[123] In

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[113] See van Dalen & Henkens, *ibid* at 138. See also Abadie & Gay, *supra* note 1; Eric J. Johnson & Daniel Goldstein, "Do Defaults Save Lives" (2003) 302:5649 Science 1338 [Johnson & Goldstein, "Do Defaults Save Lives"]; C.R. McKenzie *et al.*, "Recommendations implicit in policy defaults" (2006) 17:5 Psychological Science 414; Richard H. Thaler & Cass R. Sunstein, *Nudge: Improving decisions about health, wealth, and happiness* (Connecticut: Yale University Press, 2008).
[114] Johnson & Goldstein, "Do Defaults Save Lives", *supra* note 113.
[115] *Ibid*.
[116] *Ibid*.
[117] *Ibid*.
[118] *Ibid*.
[119] *Ibid*.
[120] *Ibid*.
[121] Eric J. Johnson & Daniel Goldstein, "Defaults and donation decisions" (2004) 78:12 Transplantation 1713 at 1714.
[122] Johnson & Goldstein, "Do Defaults Save Lives", *supra* note 113 at 1339.
[123] *Ibid*.

other words, defaults save lives.[124] The default mechanism of presumed consent has the potential to significantly increase post-mortem donation rates. But would an increase through such a framework be at the expense of individual autonomy?

Thus far we have seen how family continues to play a monumental role in organ donation frameworks. Saskatchewan's opt-in model and Europe's presumed consent model carve out a special role for substitute decision-makers. Both models are keen on maintaining a "just in case" mechanism; always reserving the family's ability to veto a deceased's consent or non-consent, "just in case" the deceased changed his or her mind about organ donation, or "just in case" the deceased died without a prior given instruction.

Although studies have shown that default legislation sways an individual's consent to donate, it is not entirely clear as to whether default legislation also influences the family's role in cadaveric procurement practices. Are families as inclined to refuse or veto consent under a presumed consent model as they are under an opt-in model, or does presumed consent have an impact on their ultimate choice as well? Generally speaking, where donative intent is unknown, it has been said that 40% to 50% of relatives refuse to consent on the deceased's behalf.[125] In the presumed consent context, while donation rates have been seen to increase by 25%-30%,[126] there will still be situations where family can and will decide to opt out from donating the deceased's organs.

Under a presumed consent model, the societal need for increased donation rates seems to be taken into account more than it has been under the opt-in framework. As we have seen, more people remain on a donor registry under a presumed consent framework, and this fact can increase the amount of post-mortem procurements. However, some might argue that individual autonomy could be violated under a presumed consent framework where a deceased person wanted to opt out of donating but was unable to do so. In such instances, advocates of this angle might also suggest substitute-decision making is actually more consistent with autonomy. Indeed, an opt-out system does provide the setting for opt-out challenges, and easily and widely accessible opt-out opportunities must be in place to mitigate against this issue arising. Moreover, some sort of evidentiary threshold should be legislated to facilitate fair and timely resolution where next of kin claim the deceased person really does not want to donate but did not opt out. Otherwise, next of kin could override the presumption of donating with mere hearsay, which alone is a problematic form of evidence in every other area of law.[127]

Conclusion

As the above example suggests, individual autonomy stands to be violated under a presumed consent model where a deceased person wanted to opt out of donating but was unable to do so and where family maintains a veto power to ultimately decide if a deceased's organs and tissue will be donated. Substitute consent provisions and the role of the family need to be carefully qualified in

[124] *Ibid* at 1338-1339; Abadie & Gay, *supra* note 1; Shepherd *et al.*, *supra* note 20; Lena V. Groeger, "Set It and Forget It: How Default Settings Rule the World – The many ways we act by default (without even knowing it) (27 July 2016), online: Pro Publica <https://www.propublica.org/article/set-it-and-forget-it-how-default-settings-rule-the-world>.

[125] Sanner, *supra* note 81 at 296.

[126] Abadie & Gay, *supra* note 1 at 599 and 613.

[127] Determining *what* the evidentiary standard should be and *how* that standard should be enforced is an aspect of organ donation that should be addressed but such analysis and discussion is beyond the scope of my thesis.

a presumed consent system. Ultimately, the presumed consent model common in European countries is not a perfect safeguard of individual autonomy. It can and does infringe individual autonomy in the same fashion as that of the opt-in framework and in doing so it undermines the potential that a default system could have in significantly increasing donation rates. In the next chapter, I suggest considerations for an improved presumed consent system; a system that not only recognizes society's need for increased donations, but also recognizes and *balances* that aspect against individual autonomy.

CHAPTER 5
Suggestions for Reform: Considerations for Presumed Consent

As previously discussed, it is important to reform the donation system to one that safeguards a deceased's consent to donate post mortem. The discussion that follows will show that a reformed presumed consent system can work to balance donor (and non-donor) autonomy more fairly against the public's need for increased donations than the opt-in framework does. In exploring common criticisms of presumed consent, we will see that most hinge on the argument that default mechanisms violate individual autonomy just as much as – if not more than – opt-in systems. As we will see, this view is a shallow misrepresentation of the default mechanism.

On the contrary, this chapter will outline specific components that are necessary for a successful presumed consent system. As we will see, a presumed consent system could actually violate individual autonomy *less* than the current opt-in frameworks if the former offered people a workable system for de-registering consent and deferring decisions to next of kin. I will outline specific components necessary for a successful presumed consent system and consider the feasibility of implementing such a framework.

5.1 Why Presumed Consent?

a) Autonomy Through De-registration

Mandated choice and presumed consent are similar in that both will place a positive burden on a certain sub-set of people. The opt-in system also places a positive burden on a certain sub-set of people, namely those that want to donate – insofar as donors have to make their intent known in the hope of having their choice realized. In theory, under a mandated choice model, everyone is required to register a choice concerning organ donation, and in having the opportunity to do so, it can be said autonomous choice has been respected. However, it could also be said that being obligated to make a choice is in and of itself violating to autonomy, since "some individuals may want to exercise their autonomy by refusing to make a decision."[1]

Similarly, while there is no requirement to 'act' or 'do something' under a presumed consent system, there will likely be a considerable number of people who will be required to do something (i.e. opt out) in order to exercise their individual autonomous choice not to donate. Moreover, some would say the presumption of consent is a blatant violation of individual autonomy. But again, much like the mandated choice policy, the *opportunity* to opt out mitigates the violation of autonomy.

One interesting observation concerning presumed consent is that this model quite literally contains a mandated choice for some people (i.e. those individuals wishing not to donate their organs would be required to take action and opt out). In this way, presumed consent is less violating to individual autonomy than mandated choice is, because under presumed consent only some people would be forced to make a choice, whereas all people must make a decision under mandated choice. Still, some critics of presumed consent view the model as excluding consent altogether.[2] To them, the

[1] Haley Cotter, "Increasing Consent for Organ Donation: Mandated Choice, Individual Autonomy, and Informed Consent" (2012) 21:2 Health Matrix 599 at 607.
[2] Charles Erin & John Harris, "Presumed Consent or Contracting Out" (1999) 25:5 J Med Ethics 365.

model is a sneaky contradiction because consent cannot exist on presumption and instead should be thought of as a 'contracting out' model.[3] These critics say that adopting 'consent' language is an attempt by policy makers to disguise the reality of the situation in order to appeal to the principle of individual autonomy.[4] Further to this point, they note:

> …by *presuming* consent, we are acting against the principle; we are being disrespectful of individual autonomy.
>
> …
>
> …in formalising a contracting-out approach for the removal of organs from cadavers, we are, in essence, articulating a particular society's view of what it is morally supportable to do with the body of a dead person, where that person has not consented prior to death to such treatment of her body after death. [5]

Opponents of presumed consent might also suggest that such a model overlooks the importance of fully informed consent. As one analysis observes, "[o]btaining consent is …one of the guiding principles that provide moral validation of organ transplant programs."[6] Another analysis states, "[p]resumed consent would violate the principle of informed consent and would infringe on individual autonomy."[7] However, others have said that whether we refer to this default model as 'presumed consent' or as 'contracting out', the end result is the same.[8] In other words, this argument is really one of semantics and under either terminology the default that presumes donative intent is still in effect. Even though "there is a faintly distasteful sense of dominance in a 'presumption' which is avoided in a 'contract'", both are actually synonymous in the context of an opt-out model.[9]

In the organ donation framework, our individual autonomy has been defined by what opportunity we have for consenting to or refusing organ donation. As one lawyer notes, "[d]ecisions about the body are 'prima facie' expressions of individual autonomy."[10] In making decisions about the body, we are either consenting to or opposing actions against it. Thus, when the process for making decisions about the body is flawed (e.g. when our consent is not binding), we consider our autonomy violated. Our intention to donate or to refrain from donating is susceptible to alteration under the current donation framework. However, in the context of post-mortem organ donation, I suggest the better approach would be to think of consent as 'intent'. If we accept that intention should determine post-mortem donation, the legal framework should be designed to ensure this intention is carried out, and any reform should be aimed at guaranteeing a deceased's previously recorded intention (whether it be intention to donate or to refrain from donating).

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[3] *Ibid*.
[4] *Ibid*.
[5] *Ibid* [emphasis in original].
[6] Joseph L. Verheijde *et al*., "Recovery of Transplantable Organs After Cardiac or Circulatory Death: Transforming the Paradigm for the Ethics of Organ Donation" (2007) 2:8 Phil Ethics & Human. Med 1, as cited by Cotter, *supra* note 1 at 605.
[7] Cotter, *supra* note 1 at 618.
[8] G.T. Laurie *et al*., *Mason and McCall Smith's Law and Medical Ethics*, 10th ed (Oxford, United Kingdom: Oxford University Press, 2016) 600 at footnote 129.
[9] *Ibid*.
[10] Cotter, *supra* note 1 at 607 citing T. M. Wilkinson, "Individual and Family Decisions About Organ Donation" (2007) 24:1 J. Applied Phil 26 at 26, 33.

As we will recall from the intestacy and wills parallel that was discussed in Chapter 2, intention plays an important role in disbursing property after death. It is trite law that the deceased's expressed intention must always tip the scales.[11] Intention is also paramount in disbursing property before death; for example, when gifting or abandoning property, and perhaps most notably when consenting to an *inter vivos* organ donation. With the view that donation laws should, first and foremost, secure the individual's intention (another way of saying individual autonomy), law makers should feel compelled to reform the donation system in a way that views intention as sacrosanct.

In guaranteeing an individual's donative intent, the donation framework should also carve out an option to defer or assign the donative decision to the next of kin; as well as an option for certain next of kin or legal guardians that have a so-called "legitimate interest" in making the decision on behalf of minors and adult-dependants that cannot de-register or defer from the default themselves.[12] Once a minor reaches the age of majority, they should then be absorbed under the default in some automatic "coming of age" way. I do not believe this idea is ahead of our time, technologically speaking, as there are already many ways in which governments track age and identity (e.g. social insurance, driver's licence, and health card registration, to name a few). Surely, we are well within an era that would allow a donation default to seamlessly apply as soon as a person reaches the age of majority.

While we continue our search for a better framework, some opponents of the default system continue likening the presumed consent model to conscription or mandatory donation. In their view, it supposedly "presupposes society's right of access to organs of any deceased person" and "[s]uch a right would rest either on the claim that society 'owns' the body of the deceased or on the premise of an enforceable moral duty all of us as humans have to allow post-mortem organ retrieval."[13] In this way, empowering family with a veto power is a way of assigning "a property interest in the body to the next of kin" and presumptions of consent would "depart from this legal principle."[14]

These observations, in my view, signal a shallow and misrepresented view of what presumed consent is and can be. First, unlike the historic understanding of conscription, the presumption is always rebuttable in that there will always be the option to opt out of a presumed consent model without punishment under law. Additionally, presumed consent models need not exclude family involvement altogether. In a presumed consent system, the opt-out process could include three options: "no – I don't want to donate", "yes, I want to donate" (with the option of specifying particular body parts or whether the body is to be used for transplantation, medical research or science) or "I assign my donation decision to my family" (with the option of designating a specific person).[15] A good presumed consent system will guarantee donor and non-donor autonomy. The

[11] See for example *Re Tilbury West Public School Board and Hastie*, [1966] 2 OR 20, 55 DLR (2d) 407 (HC); *Re McKellar*, [1972] 3 OR 16, 27 DLR (3d) 289; *Re Essex County Roman Catholic Separate School Board and Antaua*, 80 DLR (3d) 405, [1977] CarswellOnt 429 (WL).
[12] *Neuberger v York*, 2016 ONCA 191 at para 118, 129 OR (3d) 721.
[13] Verheijde *et al*., *supra* note 6 at 5-6.
[14] *Ibid* at 6.
[15] Lawyer Haley Cotter made a similar recommendation for recording wishes under the "ideal mandated choice system". In that context, she proposed three options: "yes", "no", and "defer to family wishes". See Cotter, *supra* note 1 at 616 citing Tom Farsides, "Winning Hearts and Minds: Using Psychology to Promote Voluntary Organ

option to register revised donation instructions (i.e. to donate only certain organs as opposed to all of them or to donate to medical research or science) as well as the options to de-register altogether or to defer the decision to a particular designated person, are all equally important to individual autonomy. That is why a good presumed consent system must be able to guarantee that all three types of decisions are binding.

b) Autonomy Through Deferral Option

In Chapter 1, we explored how the court in *Re JS*[16] sought to identify the person in the best position to make post-mortem determinations on behalf of the deceased. In that case, the court gave a *de facto* property right to the next of kin, whom they believed was in the best position to facilitate proper disposal. As we discussed, the court did not define "proper disposal" but recognized that customs change over time,[17] which leaves open the possibility for new ways to dispose of bodies and for new limited forms of property to facilitate those disposals. As we discussed in Chapter 2, there does not seem to be a principled reason for denying post-mortem donation powers to an individual prior to their decease. In testamentary law, it would be highly offensive to enforce a framework that gave next of kin ultimate decision-making power over what happens to the deceased's property gifted in a will.

In my view, next of kin have no interests in the post-mortem donation process except insofar as they act as substitute-decision makers when the deceased lacked capacity to make a decision before death or where the deceased assigned the decision to next of kin.[18] Any interests beyond these are overridden by considerations for individual autonomy and public policy. Therefore, legislation needs to clearly identify *when* the next of kin's decision-making power has been engaged to make decisions on the deceased's behalf. Anything short of certainty as to where next of kin belong in the decision-making process risks infringing a donor's autonomy and violating public policy. An organ donation system that takes autonomy and public policy seriously should also consider introducing a statutory or regulatory offence, chargeable whenever the next of kin's involvement has wrongfully prevented procurement.

Limiting the next of kin's role in any organ donation framework would be consistent with general constraints on actions with property. As was discussed in Chapter 3, property rights are very often constrained by legal rules. Applying this notion to organ donation, we see that our current donation framework constrains the individual from leaving binding donative instructions prior to their decease. A fairer organ donation model would balance the interest of the deceased with the public's interest in increasing donations by shifting the default away from the next of kin. Certainly, next of kin are well-placed to make decisions on a deceased's behalf, but the next of kin's interests

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Donation" (2000) 8:2 Health Care Analysis 101 at 108-109.

[16] *Re JS*, [2016] EWHC 2859 (Fam).

[17] *Ibid* at 47.

[18] In cases where the deceased either lacked capacity or assigned the decision to next of kin, the substitute decision is a determination made by the person best suited to make a decision *for* the deceased, but not necessarily in accordance with what the deceased would have wanted. In these situations, whether the substitute-decision was consistent with the deceased's wishes may be irrelevant since the deceased either lacked the requisite capacity to express intention or opted to defer the determination to next of kin. It is beyond the scope of this thesis whether substitute decision-makers in the organ donation context should be acting purely on what they believe the deceased would have wanted or if they have any interest of their own that may be expressed in their choice. In my view, a substitute-decision involves either or both of these components and how much of the decision should be rooted to one or the other varies with circumstance.

should only be considered when the deceased lacked capacity to make a decision before death or if the deceased assigned their decision to the next of kin.

There are several arguments for why the wishes of relatives should continue to carry weight in the post-mortem donation process. For example, it has been said that eliminating the next of kin's involvement in the process could turn public opinion against the transplant system.[19] Moreover, it has been argued that respecting the next of kin's wishes is consistent with respecting the deceased's wishes because of the presumption "that a deceased would not want distress caused to his or her relatives."[20] Yet, it can also be said that the next of kin are probably just as interested in avoiding the distress of being asked to verify or provide donative consent on the deceased's behalf. As one author suggests, the ideal mandated choice system would allow for registrants to select one of three options: "yes" or "no" to donation, or "defer to family wishes".[21] If the deferral is selected, "the individual should be required to state which designated person should have the authority to make the decision on that individual's behalf."[22]

The option of deferring to a designated person need not be exclusive to the mandated choice model. As part of the opt-out registry, those who are not satisfied with the presumption of consent could just as easily select an option to defer the choice to a someone else. This would be analogous to wills and advance health care directives where executors or next of kin can be empowered with discretion. A good presumed consent model would largely release the next of kin from the emotional stress of making a post-mortem donative decision on the deceased's behalf, except when the deceased has explicitly elected to assign the decision to a loved one. In this way, autonomy is respected and there is little-to-no room for disagreements from family.

Interestingly, the 2010 Canadian Survey that was discussed in Chapter 4 also asked respondents (randomly selected Canadians) if the wishes of the deceased or the deceased's family take precedence when the family does not consent to organ donation.[23] Of those surveyed, 27% think the family's wishes are followed and 70% think the deceased's wishes are followed.[24] In situations where donation wishes conflict, 88% of respondents feel the wishes of the deceased should take precedence.[25]

These statistics suggest that a majority of Canadians could be unaware that donor cards and registration systems do not actually bind individual consent, and could also suggest that public opinion is not in favour of outright excluding next of kin from the donation process. This attitude would be consistent with the position of some transplant organizations that state the family plays an essential role in the transplant process by providing the medical background of the deceased in

[19] Jonathan Herring, *Medical Law and Ethics*, 6th ed (Oxford, United Kingdom: Oxford University Press, 2016) at 469.
[20] *Ibid*.
[21] Cotter, *supra* note 1 at 616.
[22] *Ibid* at 616-617.
[23] Ipsos Reid, Canadian, "Views Toward Organ and Tissue Donation and Transplantation: Final report" (10 July 2010) at 6, online: <https://professionaleducation.blood.ca/sites/msi/files/Views-Toward-OTDT-Final-Report-2010-07-221.pdf>.
[24] *Ibid*.
[25] *Ibid*.

situations where donative intent is unknown, or is known but not registered or recorded.[26] In my view, an improved donation model would have information about the deceased's donative intent readily available so as to avoid having to approach the family for this data. However, the enhanced model would also allow potential donors to select the option of deferring their consent to the family, or to a particular designated person if preferred.

c) Donation Default Satisfies Public Policy

The process for consenting to organ donations will always be imperfect, insofar as it is impossible for one single consent system (explicit/opt-in, presumed, or mandated choice) to satisfy everyone. I have argued that the property law lens helps to shed light on why the single most important goal of any organ donation framework should be to strike a balance between individual autonomy (that is, respecting dispositive intentions concerning our own bodies) and the public need for increased donations (that is, promoting use and mitigating waste of such valuable property).

Legislatures should be asking themselves how they can strike the best balance between guaranteeing individual autonomy while also appealing to the public's need for increased donations. The presumed consent philosophy adopted across various parts of Europe has proven to increase organ donation rates and holds the potential for further increases. With the proper opt-out options, this type of default framework could be the most considerate to concerns for autonomy and increasing donation. The *presumption* of consent recognizes the need for increased donations and the *choice* to opt out or defer the decision recognizes the importance of individual autonomy.

5.2 Feasibility

Recall that the 2010 Canadian survey referenced in Chapter 4 showed nearly 50% of respondents opposed presumed consent.[27] What is it about a presumed consent model that makes it seem so radical? Quite possibly one sticking point is the belief that the default would function without a role for the next-of-kin. Indeed, any donation model without a role for the next-of-kin is unlikely to find warm reception in Canada or anywhere for that matter. Educational initiatives would be helpful in clarifying and educating people about the functional capabilities of a presumed consent model, and these initiatives could come in the form of commercials, posters, websites, information pamphlets, webinars, and so forth.

Recall also that 84% of respondents from the 2019 Saskatchewan survey (also referenced in Chapter 4) said they somewhat agreed or strongly agreed that the province should implement a presumed consent system for organ donation.[28] But is it economically feasible to implement and sustain a truly impactful presumed consent system? It is challenging to address the economic feasibility for such a framework given research gaps in this area. Costs that would be directly associated with a presumed consent system would be a user-friendly registry that provides the opportunity to opt out or defer the decision to next of kin and have that decision respected. More

[26] Herring, *supra* note 19 at 469.
[27] Ipsos Reid, *Final Report*, *supra* note 23 at 6
[28] University of Saskatchewan Social Sciences Research Laboratories, "Taking the Pulse Saskatchewan", online <https://ssrl.usask.ca/taking-the-pulse.php>. See also Andrea Hill, "Taking the Pulse: 84 per cent of Sask. Residents want presumed-consent organ donation" (3 July 2019) online: *Saskatoon StarPhoenix* <https://thestarphoenix.com/news/local-news/taking-the-pulse-84-per-cent-of-sask-residents-want-presumed-consent-organ-donation>.

generally, we observed in Chapter 4 that the success of any donation model is significantly influenced by the capacity of the transplant system.[29] The trained surgeons and transplant centers necessary to support any effective donation model will not be without a hefty price tag, and as one author notes, the costs could be viewed as serious disincentives, even though research has found that transplantation is the most cost-effective treatment for end-stage liver or cardiac failure.[30] Academics note that it is not clear to what extent obvious and hidden costs associated with an improved donation program could burden the healthcare system.[31] For example, there will be expenses associated with anesthetic and surgical times, as well increased numbers of ICU beds.[32]

In addition to these obvious expenses, less obvious ones are the healthcare costs associated with treating and continuing to treat transplant recipients, as well as salary expenses for the support staff necessary to facilitate this default program. Researchers continue to urge "transplant organizations to routinely collect data on important organ donation indices (for example, consent type, procurement type, number of intensive care beds and trained surgeons) and make this publicly available to develop future research and policy recommendations."[33] To determine the true impact and feasibility of restructuring our donation framework to an opt-out/default model, the government should conduct a research audit on the most successful organ donation programs, to assesses their key components and determine a path for reform.[34]

The cost or cost-savings of a successful transplant system will undoubtedly weigh on law reform decisions. Notwithstanding the economic impact of a robust transplant infrastructure, providing people with the best way to record binding consent is arguably a separate issue from whether a successful transplant system is economically feasible. A system that provides the best way to give consent may not be overly taxing on the healthcare budget. However, in a presumed consent system that takes the public need for increased donations seriously, i.e. where organ procurement is going to be guaranteed in all cases where competent adults die with the presumption of donating, and the deaths make transplanting medically feasible, then there is a possibility that the healthcare system will not be equipped to handle that influx of available deceased donors. For this reason, if such a system were to be seriously considered by politicians, a research audit with respect to costs would be necessary.

Conclusion

In this thesis I have argued that the property law lens illuminates sound reasoning for why such important reform is both principled and necessary to the organ donation system. In the previous chapter I argued that the default mechanism within the presumed consent system is ripe with potential for meaningful reform. Chapter 5 aimed to develop this point further by arguing that the presumed consent default mechanism and de-registration and deferral options are all key components to safeguard individual autonomy and balance it with the public's interest in increased

[29] Lee Shepherd *et al*. "An international comparison of deceased and living organ donation/transplant rates in opt-in and opt-out systems: a panel study" (2014) 12:131 BMC Medicine 1 at 12.
[30] S. Cameron & J. Forsythe, "How can we improve organ donation rates? Research into the identification of factors which may influence the variation" (2001) 21:5 Nefrologia 68 at 68 and 73.
[31] *Ibid* at 73. For a more recent study from 2014 that made the same observation see Shepherd *et al., supra* note 29 at 12.
[32] Cameron & Forsythe, *supra* note 30 at 73.
[33] Shepherd *et al*., *supra* note 29 at 12.
[34] Cameron & Forsythe, *supra* note 30 at 74.

donations. Such a system would facilitate choice and safeguard decisions, and at the same time ensure predictability as to how organs and tissue will be disposed of upon death. Ultimately, if we accept that organs and tissue are property, then a presumed consent system should be to post-mortem organ donation what wills and intestacy laws are to post-mortem property disposal.

CONCLUSION

As we saw in Chapter 1, although the common law recognizes property rights in the human body in only narrow circumstances, we know that it continues to expand. Advancements in modern technology and health care make findings of property prudent for invoking new laws, legal rights, legal duties, and so forth. The legislatures, although slow to reform organ donation statutes, are at least awake to the organ donation problem across Canada and are aware of the increasing need to reform. Governments are looking for a solution. Saskatchewan's recent 2015 reform, Alberta's second reform within 20 years, and Nova Scotia's move to a presumed consent model are all telling that this issue is alive and well – and unresolved.

As was discussed in Chapter 2 and threaded throughout this thesis, the next of kin's power to veto *inter vivos* decisions concerning post-mortem donation is a violation of donor autonomy. To date, neither the common law nor statutes explain how this veto should be interpreted and applied. Without such explanation and mechanisms for guaranteeing binding consent, the result is a system of organ donation that depends significantly on the altruism of surviving family members and ignores the public interest of increasing donations and the individual interest in having donor and non-donor autonomy secured. This is a problem. As was also discussed in Chapter 2, we do not allow such powers over testamentary property when it comes to probating a deceased's will. Disposal rules are no less relaxed when a person dies intestate. We accept that governments enforce laws to oversee and ensure how our "other property" is disposed of after we die. Will and intestacy laws govern that. A similarly aimed organ donation system that protects our donative intentions from family veto and mitigates against waste is needed in the organ donation context.

Chapter 3 explored definitions of property as described by Jeremy Waldron and Anthony Honoré and examined how their popular understandings can enhance arguments in favour of personal property ownership in organs and tissue. As we saw, limitations on the scope of ownership, such as prohibitions on sale, do not preclude something from being property. Much like other property ownership that is regulated by the law (such as prescription medications, vehicles, guns, etc.), body parts should also be viewed as a type of property requiring limitations on how they can be alienated from one owner to another. As further discussed in Chapter 3, our choices concerning where our post-mortem body parts go are not safeguarded by the same protections afforded to our choices concerning property. This is because property is largely understood to be an enforceable right to a particular thing, and an object that may be property is only truly property if law enforces or gives effect to ownership rights surrounding it. By exploring natural law and legal positivist theories, I argued that the enforceability of ownership rights in organs and tissue is not only consistent with popular definitions of property, but is also substantiated further by two ostensibly contrasting theoretical views of jurisprudence.

As I aimed to illustrate in this thesis, if the donation shortage is to be taken seriously, law reform must respond to the problems generated by the continued and substantial loss of potential donors each year. Worthwhile law reform must recognize that the success of any donation system cannot hinge on substitute decision-making, and imbuing organs and tissue with principles of property can guide lawmakers to a better donation framework. Through the property law lens, we should see organs and tissue as personal property capable of first-person ownership. Property is the common thread that runs through the frameworks of organ donation, wills and intestacy. Each framework deals in property and has autonomy and the public interest at stake. Ultimately, property is the

subject of all post-mortem dispositions and the law is the driving force behind effective transfers of property. In the context of organ donation, post-mortem donative instruction should be viewed as sacrosanct (as I noted in Chapter 2), much like the testator's instruction is viewed in the law of wills. In introducing this thesis, I suggested that organs and tissue are among the most valuable 'things' in this world. The property law lens should encourage the view that organ donation frameworks can (and should) mitigate the waste of such precious property by facilitating donation more effectively and as much as possible.

In Chapter 4, we explored whether mandated choice and presumed consent jurisdictions tap into the "potential donor pool" better than opt-in frameworks, and how individual autonomy and public policy fare under each system. In examining other countries, we observed that mandated choice had little to no effect on increasing donation rates because those jurisdictions (namely, Texas and Illinois) do not actually mandate people to make a choice regarding organ donation. In presumed consent countries, we observed that family continue to have a veto power in all opt-out countries. We also observed that the default mechanism of presumed consent is not solely responsible for increasing donation rates in presumed consent countries like Spain. Other factors contributing to higher donation rates included procurement training for medical practitioners, transplant coordination teams, donation campaigns, but especially how physicians approach requesting donations from families.

We also observed that a presumed consent system stands to violate individual autonomy where deceased people want to opt out but are unable to do so, or where family maintains a veto power to ultimately decide if the deceased's organs and tissue will be donated. Chapter 5 therefore posed suggestions for an improved presumed consent system that carefully qualifies the role of family, safeguards individual autonomy and balances those components with the public need for increased donations. Ultimately, donation levels are directly impacted by the way in which lawmakers frame legislative options for organ donation. Lawmakers should provide options that result in the highest level of donation. To do so, they must recognize that increasing donation rates does not need to be at the expense of individual autonomy.

As stated earlier in this thesis, consent should be viewed as the protector of autonomy. As this thesis has aimed to show, presuming consent or mandating choice no further violate individual autonomy than our current opt-in framework. Quite the reverse, a system requiring someone who does not want to be a donor to opt out, and that removes the ability of family to decline donations, seems to more fully respect autonomy than a system which requires an intended donor to opt in and that requests the family to validate prior given consent. Lawmakers need to recognize that presuming consent, mandating that a choice be made, and offering de-registration and options to defer the decision to family or a designated individual to decide after death are achievable under one donation framework, and together these components can increase donation rates and safeguard individual autonomy.

I noted it once before in this thesis and I will conclude on this point: it remains a surprise to me that the organ donation laws have yet to be litigated. If governments fail to meaningfully reform these laws, I am all but sure that this issue will eventually end up before the courts.

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